Mental Health Services 2010

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA	Dublin Mid-Leinster
HSE AREA	Dublin Mid-Leinster
CATCHMENT AREA	Dublin South City
MENTAL HEALTH SERVICE INSPECTED	Dublin South City
RESIDENCE INSPECTED	Quilca
TOTAL NUMBER OF BEDS	10
TOTAL NUMBER OF RESIDENTS	10
NUMBER OF RESPITE BEDS (IF APPLICABLE)	None
TEAM RESPONSIBLE	General Adult
DATE OF INSPECTION	29 September 2010

Description

Service description

Quilca 24-hour high support residence was a large Victorian terraced house on a residential road, close to Terenure village in Dublin. It was opened as a residence in 1995 and two of the residents had been there since it opened. Staff emphasised a recovery model of care and a small number of residents had progressed from the residence to more independent living. In addition, in the past three years, three residents had been transferred to nursing homes because of increasing physical health needs. Although the service operated a recovery model, the residents were under the care of general adult teams as the service did not have a rehabilitation team.

Profile of residents

At the time of inspection, there were five male and five female residents who ranged in age from 32 to 74 years, two of whom had been resident for 15 years. The most recent admission was in March 2010. There was a waiting list for admission to the residence and all referrals were discussed at the referral committee, which was held monthly. The predominant diagnosis of the residents' was schizophrenia.

Quality initiatives and improvements in the last year

- A key-worker system of care was introduced.
- A new individual care plan had been introduced which incorporated individual goals in a recovery model.
- Bank accounts had been set up for each resident in a local bank.

Care standards (based on Mental Health Commission- Quality Framework for Mental Health Services in Ireland 2007 and the 2008 inspection self-assessments)

Individual care and treatment plan

All residents had an individual nursing care plan, which incorporated an MRC (Medical Research Council) Assessment. This individual care plan examined two areas of function in an individual's life, namely the level of functioning in relation to mental illness and the level of social skills functioning. The Clinical Nurse Manager 2 (CNM2) had trained in the implementation of this particular care plan. Individual care plans were done in conjunction with the resident, and were signed by them. Residents were reviewed by the non consultant hospital doctor (NCHD) every two months and by the consultant psychiatrist yearly. Access to social worker and psychologist was as required. The occupational therapist provided a service for individuals and groups both in Quilca and in the day centre. Physical health reviews were carried out by the individual's general practitioner, and all physical health care was the responsibility of the general practitioner.

Therapeutic services and programmes provided to address the needs of service users

Most of the residents attended therapeutic services and programmes outside the house. A number of them attended a day centre run by the service and travelled there by public transport. Two residents worked in sheltered employment, and one attended college. One older resident attended a local early retirement group and participated in activities there. The occupational therapist attended the house for one session per week, and also provided a session in the day centre.

How are residents facilitated in being actively involved in their own community, based on individual needs

The residence was situated in a residential area and residents had easy access to the local shops, bank and public transport. Most of the residents do not need to be accompanied and make their own way to and from the house. Staff regularly accompanied residents who were unable to cope on their own to local shops, coffee shops and to purchase necessities.

Do residents receive care and treatment in settings that are safe, well maintained and that respect right to dignity and privacy

The residence was an old house but reasonably well maintained. Regular maintenance was carried out and the maintenance team responded quickly when required. There were adequate sitting room areas and a pleasant kitchen. The back garden was paved and private. However, there was little privacy in the bedrooms, apart from the one single room. There were three twin rooms and one room with three beds. These rooms were cramped and there was no privacy for residents. There were no partition curtains in any of the rooms.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	Monday – Friday: 1	0
Staff Nurse	1	1
Household Staff	Monday - Friday:0.75 whole-time-equivalent	0

Team input (sessional)

DISCIPLINE	NUMBER OF SESSIONS
Consultant psychiatrist	None dedicated
Non Consultant Hospital Doctor (NCHD)	None dedicated
Occupational therapist	1 per week
Social worker	None dedicated
Clinical psychologist	None dedicated

Team input

The residents were under the care of a number of sector teams and were reviewed yearly by the consultant psychiatrist. The residents did not meet with a multidisciplinary team but could be referred

to a health and social care professionals if indicated. The non consultant hospital doctor visited the residence every two months, but residents were reviewed in the out-patients department more frequently if necessary.

Medication

Medication kardexes were reviewed every two months by the non consultant hospital doctor, and medication was procured monthly. Psychotropic medication was dispensed directly from the kardexes by the local pharmacist, but all other medication had to be transcribed by the general practitioner onto a medical card prescription. Some depot medication was administered by the staff in the residence, but also by the general practitioner or in the out-patient department.

Tenancy rights

The house was owned by the Health Service Executive and there were no tenancy arrangements in place. Residence was dependent on clinical need and suitability for the residence. Community meetings were held monthly, and the advocate visited the house regularly. A record of complaints was kept.

Rent was paid by the residents, and this was means tested. The Clinical Nurse Manager 2 received a monthly sum from the Health Service Executive for the running of the house.

Financial arrangements

All residents had their own bank accounts in the local bank and had access to their money. A small amount of money was held in nurse’s office for those residents who required supervised access to money.

Leisure/recreational opportunities provided

Regular outings to shops, for coffee and to the cinema were arranged by staff for residents. There was an annual holiday for all residents accompanied by staff who gave freely of their time.

Service user interviews

Many residents were not in the house at the time of inspection, as they were attending day programmes. Short conservations were held with the residents who were there at the time of inspection.

Conclusion

Although the residents in Quilca were not under the care of a rehabilitation team, there was evidence that a recovery model of care was in place. Residents were involved in their individual care plan and most of them were engaged in therapeutic services and programmes outside the house. The location of the house provided easy access for residents to local shops and public transport, which many of them availed of. Whilst the standard of maintenance was reasonably good, the bedrooms were small and cramped and did not provide any personal areas of privacy for residents.

Recommendations and areas for development

1. A rehabilitation team should be appointed to the service.

2. A review of bedrooms should take place to examine how privacy could be improved for residents.

3. Residents should have a full multidisciplinary team review.