

## **Inspectorate of Mental Health Services 2013**

### **REPORT**

#### **Toghermore Residential Unit, East Galway Mental Health Services**

**The Inspector was informed that Toghermore, 24-hour supervised residence in Tuam, Co. Galway was being closed immediately following a fire safety inspection by a private company requested by the Health Service Executive (HSE). Concerns had been expressed through the media and in phone calls to the Mental Health Commission about the future of the current residents in the unit.**

**An inspection was carried out on 7 January 2013.**

**This consisted of a meeting with the Senior Management Team and the Area Manager for Galway, Roscommon. A visit was then carried out in Toghermore and the inspector met with residents and staff.**

**Factual corrections from the Health Service Executive (HSE) of the draft report were received by the Inspectorate and are incorporated in this report.**

#### **BACKGROUND**

Toghermore was a 24-hour supervised residence located two miles from Tuam, Co. Galway. It was a spacious period house that had recently been upgraded to a very high standard. It was set in attractive rolling countryside. It had 14 residents with four additional appropriately utilised respite/crisis beds. Some residents had been there 15 or 16 years, one resident for 25 years. Sleeping accommodation was in double or single rooms, each with its own TV. Bathroom and toilet facilities were excellent. There was a recreation room, a TV room, a visitors' area and an excellent dining facility with a choice of menu where staff and public ate with the residents. There were two nurses and two care assistants during the day and two nurses on duty at night. All residents had individual care plans which were regularly reviewed and attended activities in the next door Recovery Centre. There was also a day centre, day hospital and Recovery Centre on campus and the HSE stated that these services would remain.

The HSE had decided to close the residence as soon as possible following a fire safety inspection by a private company requested by the HSE. The fire inspection report was delivered to the HSE in December 2012 and highlighted significant risks to residents and staff which needed to be addressed as a priority. Staff were met on December 17<sup>th</sup> by the consultant psychiatrist, director of nursing and business manager and were advised of the situation. There was also a meeting to which the HSE had been invited by the local TD to update him on the current position. Residents were not invited to the meeting. The HSE stated that a local steering group was formed and met to address the challenges outlined in the fire inspection report and other general safety management matters. The steering group consisted of the clinical director, a consultant psychiatrist, director of nursing, business manager, occupational therapy manager and team leader social worker. The HSE stated that the lead consultant psychiatrist for the area had informed all residents and their families of the position prior to Christmas. It was continuing to liaise with residents and families and had included service user representation in the steering group. The HSE stated that a "comprehensive review of all health services currently being provided in the Tuam area is underway" in 2013.

The HSE stated that “the steering group was tasked with a process which would have taken into account the wishes and choices of the residents” They stated that a “media frenzy interfered with this process”.

### **MEETING WITH SENIOR MANAGEMENT TEAM AND AREA MANAGER**

The inspector met with the Area Manager Galway/Roscommon and the Senior Management Team. The Area Manager said that under no circumstances would the HSE change their decision to close the residence. It would cost €265,000 to address the fire safety issues plus additional provisions bringing the cost closer to €500,000 and it would not be possible to find this money within the current financial constraints. The HSE would not be opening another 24-hour supervised residential unit and the residents would be put into residences where they could find vacancies, and this could be anywhere in the catchment area. The Area Manager stated that it would be on a phased basis but was unable to give a time-line. In the meantime nursing staff were conducting hourly fire inspections of each room in the residence.

The Area Manager said initially that all residents would be placed in 24-hour supervised accommodation but that it could be in a different area to their current location. However at a later stage the HSE stated that arrangements had commenced immediately to relocate the residential cohort of patients to alternative mental health residential units in Tuam and no further admissions to Toghermore would take place. The residents were to visit these residences to see them as vacancies arose.

The consultant psychiatrist for the area had carried out a review and clinical assessment of all residents in Toghermore and the HSE stated that the consultant psychiatrist was “closely involved in the relocation process”.

### **INTERVIEW WITH STAFF IN TOGHERMORE**

Nursing staff expressed concern at the proposed closure. They said they had no information apart from the fact that the residence was closing as soon as possible and were therefore unable to reassure or give information to residents. The HSE refutes this and states that “staff were kept fully informed at all times”. The staff stated that residents were distressed and fearful about the future.

Consultant staff said that there were no current vacancies in 24-hour supervised residences. However the HSE stated that there were “some vacancies in other facilities”.

### **INTERVIEW WITH RESIDENTS**

The inspector spoke with residents at length. All residents who spoke said that nobody had informed them of the closure, they had heard about it on the local radio and in the newspapers. However the HSE states that the residents were met individually by the Consultant Psychiatrist.

The residents were fearful and distressed and had no idea where they would be going. A number stated that they had nowhere to go and they did not want to move, either from the residence or out of the area. They said nobody had discussed this with them. It was obvious that a number had a high level of disability and were unable to articulate their wishes.

Some of the comments from the residents were as follows:

“ I don’t know where I am going to go”

“I have nowhere to go, I have no other home”

“My family don’t want me”

“I want to stay in Tuam”

“Will we all be going to different places?”

“What will happen to us?”

“Can you help us?”

## **SUMMARY**

Toghermore, an 18-bed residential unit, was due to close in the immediate future as it did not meet fire safety requirements. The HSE stated at the meeting with the inspector that it would not be correcting the deficits as it said it would be too costly with a cost possibly rising to €500,000. The HSE stated that "The works carried out to date to the Toghermore Complex will be taken into account by management and Estates and the best possible use of the Toghermore Complex will be established".

Residents stated to the inspector that they were not informed of the decision to close the residence and they had first heard about the decision in the local media and they said they had no input or offered any choice as to where they were to live. The HSE do not agree with this and say that all residents and their families were fully informed prior to Christmas 2012. On talking with residents, it was evident to the inspector that the residents were fearful, bewildered and distressed.

No information was forthcoming about the future placement of the residents apart from the fact that they would continue to receive 24-hour nursing supervision. Vacancies in the current 24-hour residential settings in East Galway were not currently available according to the consultant psychiatrists. A review of residential places is currently being undertaken by the HSE.

## **CONCLUSION**

In speaking with the residents on the day of inspection it was obvious that they felt that they had not been informed of the proposed closure of the residence. However the HSE was insistent that the residents and their families were informed. It appears from later correspondence from the HSE that liaising with residents, families and staff is ongoing. It appeared that no account was taken of the wishes or choices of the residents. However, again the HSE state that the Steering Group were "tasked with a process that would take into account the wishes and choices of the residents." This was not evident when talking with the residents and it was quite clear that they did not know to where they would be relocated or what plans had been made for them.

That such discrepancies of account would be present between the HSE and the residents requires attention. It is not acceptable that the residents would be so distressed and confused after a process of information-giving had taken place.

While the safety of residents and staff were the "only concern" of the HSE, service users, as citizens, also have a right to information given in a way that is understandable, and right to have a say in where and how they would like to live.

There was no sense at the meeting on 7 January 2013 with the inspector, senior management and area manager as to where these residents would be located. Consultant psychiatrists stated that there were no vacancies in the community residences and the HSE stated that new residences would not be opened.

It is reassuring that a full review of current residential placement is now taking place. Every effort should be made to offer a choice of location to the residents, relocate them in familiar areas where they can continue their therapeutic programmes and, as many residents have been living together for many years, to make arrangements for those that wish to continue to live together to do so.