Mountain View

ID Number: RES0017

24-Hour Residence - 2017 Inspection Report

Mountain View
Dublin 10

Community Healthcare Organisation:
CHO 7

Team Responsible:
Rehabilitation and Community Mental Health

Total Number of Beds:
17

Total Number of Residents:
14

Inspection Team:
Noeleen Byrne, Lead Inspector
David McGuinness

Inspection Date:
11 April 2017

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
20 April 2018

Contents

Introduction to the Inspection Process

This inspection and report were guided by the themes contained in the Mental Health Commission Quality Framework.

Services will be aware of the Audit Toolkit deriving from the Quality Framework and may wish to consider using this Toolkit in pursuing service improvement within the residence involved.

Service description

Mountain View was a 17-bed, purpose-built, community residence situated in West Dublin. The building opened in 2010. It was a two-storey structure, designed internally as three houses, each with its own entrance door. Each house had one downstairs bedroom, and all rooms were single rooms with en suite bathroom facilities. It was located adjacent to a primary care centre.

Residents in Mountain View were under the care of either the rehabilitation team (11 residents) or the community mental health teams (3 residents). All residents required continuing care because of long-term health needs. There were 14 residents at the time of the inspection, 12 of whom had lived in the house since it opened and had previously lived in a community residence in Crumlin, which had closed.

Care and treatment

There was no policy on individual care planning, but all residents had an individual care plan (ICP). These ICPs were developed and reviewed by the medical and nursing staff and were not multi-disciplinary. There was an occupational therapist and social worker attached to the team, and they reviewed residents by referral. When they were working with individuals, their needs, goals, and interventions were incorporated in the ICP. There was no psychologist because the position was vacant. Residents were invited to attend their care plan meeting, held in Mountain View, and to input as they wished. The ICPs were reviewed at least every six months and more frequently as required.

Psychiatric evaluations were documented in the clinical file at least six-monthly. A key worker system was in operation to support residents.

Physical care

Eleven residents attended GPs in the adjacent primary care centre, and three residents chose to remain with their family GPs. General physicals were completed at least every six months and documented in each clinical file. Information was available in relation to screening programmes, and residents received appropriate screening. Residents had access to a dentist, dietician, speech and language therapy, and general hospital services.

Therapeutic services and programmes

There was no policy on therapeutic programmes. The programmes delivered in the house included art therapy, health education and pet therapy. Staff aimed to facilitate two groups per day. An occupational therapist provided a six-week cognitive adaption training programme for one resident. An activation nurse facilitated activities one weekend per month. Eleven residents attended either day centres or training centres in the community.

Medication

There was a policy on medication management. Medication was prescribed by the GP, the consultant psychiatrist, and/or a doctor from the team. The Medical Prescription Administration Record contained valid prescription and administration details. Two residents had been trained to self-administer their medication. A local community pharmacy supplied the medication to the residence, where it was stored in a locked cabinet in a clinical room.

Community engagement

The location of Mountain View facilitated community engagement. Local bus routes enabled residents to make weekly visits to the post office, the bank, or to Liffey Valley shopping centre. One resident went into town occasionally. A local taxi service was also available to residents. Mountain View had its own people carrier, and three staff could drive residents to appointments and to activities.

Residents attended the local gym, the Jolly Club in Ballyfermot Resource Centre, and Cherryfield Mental Health resource centre. Some residents attended the Bungalow, a community project run by a voluntary agency. Residents went on outings to the cinema and to Phoenix Park, and most residents attended mass on Sunday. The Roman Catholic priest attended the residence once a month.

Autonomy

All residents were free to come and go as they desired; however, some residents only went out when accompanied by a member of staff. Residents had use of the kitchen facilities and were free to make hot drinks and snacks or light meals. All residents had a single room and they were free to determine their own bedtime. They did not have keys to lock bedrooms.

Residence facilities and maintenance

The residence was owned by the HSE. The exterior of the building was well maintained, but the shrubbery flower beds at the front of the building and in the rear garden were not well maintained. There were cigarette butts that had not been disposed of correctly at the rear of the building. All residents entered Mountain View through the same front door, which led to three hall doors – one for each internal house. Each house had two living rooms, a kitchen, an office, and two store rooms. In addition, each house had one bedroom downstairs. Several leather couches were badly torn and needed to be repaired or replaced. The bedrooms and bathrooms were cleaned daily. The living accommodation had not been cleaned, and the kitchens and ovens in the three houses were in need of a deep clean.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager	1	
Registered Psychiatric Nurse	1	1
Health Care Assistant	1	1
Multi-Task Attendant	1	

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	By referral
Social Worker	By referral
Clinical Psychologist	0
Art Therapist	Weekly
Activation Nurse	One weekend monthly

Medical Staff	
Consultant Psychiatrist	Weekly
Non-Consultant Hospital Doctor	Weekly

Complaints

There was a policy on complaints and the residence adopted the HSE's *Your Service, Your Say* policy. The process for making a complaint was displayed in a prominent position. All staff were responsible for addressing complaints, and there was a complaints log. Community meetings were held once a month and minutes of these meetings were kept. There was a suggestion box located in the hall.

Risk Management and Incidents

There was a risk management policy in the residence, and the safety statement was up to date. The torn couches were entered on the risk register in 2015, November 2016, and March 2017. Risk assessments were carried out for each resident. The risk manager for CHO 7 was looking into securing vibrating pillows for residents with hearing impairments. These pillows will link into the existing fire alarm.

Any incidents were reported through the National Incident Management System. The residence was physically and therapeutically safe.

Financial arrangement

There was a policy on managing finances. All residents received pensions and many chose to manage their own money. Nine residents had post office or bank accounts and paid a rent of €90 per week. Five residents had an arrangement whereby an AG3 form was submitted to the Department of Social Welfare, which transferred the pension to the Patient Private Property and Assets unit in Tullamore. A HSE administrator in the area drew down money on behalf of the residents, some of which was used to pay the rent. Staff of Mountain View then requested money for the residents to spend on personal items or activities. This was recorded, and there were two signatures for all withdrawals. Residents paid for their own holidays and were saving for the 2017 holiday.

Service user experience

The inspection team spoke to five residents, all of whom confirmed that they enjoyed living in the house. Two residents showed the inspectors artwork displayed in their bedrooms. While residents spoke of going out regularly, the minutes of the monthly meetings indicated that residents wanted more outings.

Areas of good practice

1. The consultant psychiatrist was leading an initiative to establish a protocol for deaf residents. This would extend to two or three other residences in the area.

2. A functional needs assessment was planned for all residents.

3. An assertive outreach team had started a housing forum and identified residents who could develop skills to live independently in the community.

4. A series of audits had been completed to highlight areas for quality improvement.

Areas for improvement

1. The leatherette couches were in a poor state of repair.

2. The garden area was not well maintained

3. There was a lack of multi-disciplinary team involvement in individual care planning.