Mental Health Services 2011

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA	Dublin North
HSE AREA	Dublin North East
MENTAL HEALTH SERVICE INSPECTED	Dublin North
RESIDENCE INSPECTED	Carlton House
TOTAL NUMBER OF BEDS	10
TOTAL NUMBER OF RESIDENTS	9
NUMBER OF RESPITE BEDS (IF APPLICABLE)	0 (unless bed is available)
TEAM RESPONSIBLE	Community Rehabilitation Team
DATE OF INSPECTION	7 July 2011

Description

Service description

Carlton House was a detached two storey residence, established in 2000 as a community Rehabilitation service for former in-patients of St. Ita's Hospital. Prior to that it was a private residence and was situated in its own extensive grounds. It had large gardens both front and rear, which while tidy, were underdeveloped. There was a general air of neglect externally and internally in this house, which had not been properly maintained for many years. It was shabby and institutional in appearance and in need of painting and redecoration. On the day of inspection staff reported that the only member of the maintenance staff from St. Ita's Hospital was painting some of the downstairs rooms. However, they reported that that he did not have a remit to completely paint the house.

Furniture was shabby. The wooden floors had been allowed to deteriorate to the point that staff had been informed that they could not be refurbished.

The house was situated in an isolated rural area of north County Dublin about six kilometres from Swords.

Profile of residents

There were two female and seven male residents whose ages ranged from thirty to fifty-two years of age. All had previously been resident in St. Ita's Hospital. The last admission was in 2010 and there was just one discharge in 2011. One resident had been there since the service opened in 2000. Staff reported that the younger residents valued their independence. They said that five of the residents could be moved on to lower support accommodation if beds were available. However, they were not and the lack of alternative accommodation meant that the service was not available for new referrals.

Quality initiatives and improvements in the last year

- A medication 'blister pack' had been introduced for residents enabling them to collect their own medication from the community pharmacy.
- Gym equipment had been purchased for use of residents.
- Some downstairs rooms had been painted.
- Internet access had been obtained and staff were using this facility to resource information and compile a brochure on community facilities for residents.

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

Residents had their own individual care plans (ICPs) which were reviewed on a rotational basis by the multidisciplinary team which met in the house every three weeks. A rota was displayed on the staff notice board. There was a facility on the ICP for the residents to sign the form and this was done in two of the three clinical files that were reviewed. Staff reported that residents participated in the meeting with the team to discuss their care. Some sections of the ICP were being completed more frequently than others e.g. the section on culture and spirituality was rarely completed.

Clinical records were well maintained with entries from medical, nursing, and social work and occupational therapy staff.

There was an excellent system of case summary documentation which was completed by the non consultant hospital doctors. This facilitated a seamless transition from hospital to community and between mental health team members over time. However these summaries were not always signed. One 2009 social work entry made reference to another set of notes being maintained in the community mental health team headquarters. Nursing staff were unaware if another set of notes existed. Clarification was later provided to the Inspectorate that social work assessments were kept separately in the rehabilitation team headquarters.

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

All residents attended the REACH or DELVIN rehabilitation services on a daily basis. There, music, art and drama were available and residents were accompanied on outings. Staff reported that the programmes provided were not linked formally with the individual care plans and that the procedure was being reviewed to facilitate closer cooperation between the services.

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

Staff reported that all residents were actively supported by their families and they often returned home at weekends. Those not at home were sometimes brought on outings e.g. to the local cinema.

Staff reported that funding shortages had impacted on their ability to participate in community activities. However, they had recently contacted local businesses and organisations in order to develop a discount system and a list of these resources were available in booklet form.

The isolated nature of the house and the infrequency of the bus service meant that residents found it difficult to travel independently. A people carrier owned by the service was old and broke down frequently. On the day of inspection it was in for repair and the service had use of a replacement vehicle.

The residents were not linked in to community groups although staff reported that such involvement was being considered.

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

This community residence was poorly maintained. It was neglected and institutional in appearance. The patio area at the rear of the building had loose pavement tiles. A back wooden door had never been painted. There was some attractive flower planting at the edge of the patio. The garden at the back was divided into two sections. A sewage tank occupied a large section at the entrance to the second garden. This had overflowed in the past. Staff reported that the sewage in the house periodically blocked up and needed to be mechanically cleared.

Environmental Health Officer reports were provided on a six-monthly basis. Some recommendations made in 2010 had not been followed up. These included recommendations with regard to the plumbing and the sewage, a leak from an upstairs shower, the repair of the floors, the provision of fly screens in the kitchen and the replacement of radiators in the bedrooms which were rusted. Many of the maintenance problems identified at a meeting between staff and the maintenance department of St. Ita's Hospital in November 2010 had not been addressed.

A painter was on the premises on the day of inspection. He reported that he was the only available member of the maintenance staff for the North Dublin Service. The downstairs kitchen, dining room, conservatory and laundry room had been painted and were bright and welcoming in appearance.

A large sitting room was comfortable, but somewhat dated in appearance.

There were no curtains or blinds on the conservatory making it vulnerable to extremes of temperature. The varnish on the wooden armchairs was worn and needed to be redone. The wooden floors throughout the building needed to be renovated or replaced. The seat of one chair was stained.

Staff reported that the HACCP food safety standards were in place and three members of staff had been trained. However, on the day of inspection the protective sealant was observed to be missing from the wall near the cooker and the backing was loose.

The carpet on the stairs and upstairs landing was worn and dirty looking. The same carpet was on the upstairs bedrooms which were grubby in appearance. The banister paint was peeling.

There were seven bedrooms, four single and three double of which two double rooms were upstairs. Some of the rooms were comfortably personalised by residents. However, some appeared bare and smelled musty. One upstairs shower was out of order as it had overflowed the previous week. Staff reported that there was some doubt about the drainage system for the shower. While some of the tiling in the bathrooms was in good condition, the surrounding paint work was in poor condition. A leak in a bathroom had recently been repaired but the panelling had not been replaced on the bath. Mould was visible in one downstairs bathroom. There was some evidence of mould on a blind in one room.

Within the staff office some medication was kept in a cupboard and some was kept in a small domestic size fridge, neither of which could be locked. Staff reported that requests to have a lock put on the cupboard had not been addressed.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
Nursing	1 CNM2+1 RPN +1 4th year student nurse intern	1 RPN+CNM3 cover
Care Staff	1	1

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non Consultant Hospital Doctor (NCHD).

Team input (sessional)

DISCIPLINE	NUMBER OF SESSIONS
Consultant psychiatrist	3 hours monthly
Non Consultant Hospital Doctor (NCHD)	1 day per week or as required
Occupational therapist	Attends ICP meeting monthly
Social worker	As required. Attends ICP meeting and provides WRAP program for residents
Clinical psychologist	0

Team Input

Staff reported that the complement of nursing staff was insufficient because of the frequent absence of staff on agreed leave or night rostering arrangements. This frequently resulted in just one member of staff being on duty during the day. This impacted on the range of services that could be provided.

The rehabilitation team had no access to a psychologist.

Medication

All service users attended their own general practitioner (GP) who prescribed both psychiatric and general medication. Staff reported they were in contact with the GPs and a rota was maintained of the review dates for six-monthly reviews. A record of resident attendance at the reviews was maintained in the clinical files. Depot injections were administered by the nursing staff. All residents received antipsychotic medication, and of these, over half were on more than two different antipsychotic medications. Medication kardexes were well written and were legible; all except two had been recently re-written and were in date, and all prescribing doctors had written their Medical Council Numbers (MCN). Where a medication had been discontinued, there was no signature to indicate who had discontinued it.

MEDICATION

NUMBER OF PRESCRIPTIONS:	9	%
Number on regular benzodiazepines	3	33%
Number on more than one benzodiazepine	0	0
Number on PRN benzodiazepines	2	22%
Number on benzodiazepine hypnotics	2	22%
Number on Non benzodiazepine hypnotics	2	22%
Number on PRN hypnotics	0	0
Number on antipsychotic medication	9	100%
Number on high dose antipsychotic medication	2	22%
Number on more than one antipsychotic medication	6	66%
Number on PRN antipsychotic medication	0	0
Number on Depot Medication	1	11%
Number on antidepressant medication	4	44%
Number on more than one antidepressant	0	0
Number on antiepileptic medication	2	22%
Number on Lithium	1	11%

Tenancy Rights

No admissions had taken place in 2011. Staff reported that no lease was signed, but that on admission a contract was signed by the service user. The contract specified house rules to which the resident should adhere e.g. no drinking or drugs were allowed, residents should help with the cleaning, be respectful of others, pay their rent, attend day services and let staff know when they were likely to return if they went out.

The HSE complaints procedure was available, although staff reported that there were no complaints. An exception was that residents had made a complaint in relation to the imminent raising of their rents. This was recorded in individual clinical files although no complaints book was maintained.

Financial arrangements

Staff reported that most residents were in receipt of social welfare incomes of one hundred and eighty euro per week approximately. Out of this they paid 96 euro in combined rent, food and housekeeping costs. This was collected by staff weekly and sent to the finance department of St. Ita's Hospital. Fifty euro per week was refunded to the staff who had to physically collect the money from the hospital. The weekly income for the running for the house for all the residents was therefore four hundred and fifty euro. Staff reported this was insufficient to facilitate rehabilitation activities. There was no money for buying extras for the resident's e.g. to celebrate birthdays, or engage in activities at weekends.

Staff were in the process of opening bank accounts for residents so that their rent could be lodged and paid by direct debit to St. Ita's Hospital. Staff reported that the hospital was to introduce procurement cards soon to facilitate easy transfer of money for housekeeping and food purchase.

Residents had recently been informed that their rent was to increase to one hundred and five euro per week. They had formally complained to the HSE about this and had engaged a solicitor to act on their behalf.

Leisure/recreational opportunities provided

Daily services were provided by REACH and DELVIN rehabilitation services. Each weekend residents went to the cinema either alone, or where that was not suitable, accompanied by a staff member. Occasional picnics or trips to Carlingford were organised by staff.

Service user interviews

No service user expressed a desire to speak to the Inspectorate on the day of inspection.

Conclusion

According to their own literature, this community based residence aimed to provide residents with the highest quality of care, to treat them with dignity and respect and help them live as independently as possible. However, it was clear that the service was insufficiently resourced to do this and did not meet the criteria for a Recovery based service.

There was a general air of neglect throughout the building which was institutional and grubby in spite of being domestic in size and located in a pleasant rural residential area**.** Repeated requests for maintenance had not been addressed. Appropriate move-on accommodation was unavailable to those residents who would be suitable for medium rather than high-support accommodation. Requests from nursing staff for the funding of rehabilitation activities remained unmet. Easy access to independent transport was unavailable and the transport supplied by the HSE was unreliable. There were some difficulties with regard to the rostering of staff to ensure that two nurses were available each day as per the staff complement.

On the positive side, staff appeared to have a good relationship with residents who seemed to be at ease within the house. Residents were encouraged to do their share of chores, according to a rota which was displayed on the notice board. They were encouraged to maintain their own rooms and some had accumulated their own belongings there, making the rooms homely. Staff had made use of the internet to access local resources.

Recommendations and areas for development

1. *Appropriate move-on accommodation should be provided for those residents suitable for a lower level of supervision.*
2. *The extensive maintenance issues should be addressed as a matter or urgency.*
3. *Appropriate funding for the provision of a modern Rehabilitation and Recovery service should be provided.*
4. *Greater involvement of residents in community groups should be encouraged.*
5. *The service should be visited by a representative of the Irish Advocacy Network.*
6. *The community rehabilitation team should be fully resourced.*
7. *Plans to facilitate easier money transfers should proceed.*
8. *There should be a closer link between the individual care plans developed by the residential and the rehabilitative (REACH and DELVIN) services.*
9. *All documentation in the clinical files should be properly signed.*
10. *There should be one composite set of clinical records.*
11. *A complaints register independent of the clinical files should be maintained.*
12. *Doctors should sign the medication kardex when discontinuing a medication.*