Mental Health Services 2013

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Carlow, Kilkenny, South Tipperary
HSE AREA	South
MENTAL HEALTH SERVICE	Carlow
RESIDENCE	Elm Park, Rathnapish, Carlow
TOTAL NUMBER OF BEDS	8
TOTAL NUMBER OF RESIDENTS	6
NUMBER OF RESPITE BEDS (IF APPLICABLE)	0
TEAM RESPONSIBLE	Rehabilitation
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	22 August 2013

Summary

- This 24-hour community staffed residence opened five years ago and was located in a housing estate approximately a half mile from Carlow town. Originally a family home, the house had five bedrooms with sleeping accommodation laid out in three two-bedded and two single-bedded rooms.
- Residents ranged in age from the mid 50s to 80 years of age. Mobility was an issue for some residents and the house was not suitable in this regard as there was a steep staircase.
- The rehabilitation team looked after the residents. Each resident had an individual care plan and residents were reviewed by the responsible consultant psychiatrist at least every quarter or more frequently if required. Physical health reviews had been completed every six months for each resident.
- Residents chatted with the inspector and appeared very much at home in the residence. Bedrooms were personalised with residents' belongings.

Description

Service description

The two-storey residence was in a residential area and located approximately a half mile from Carlow town. The house was not purpose built, was originally a family home and had opened as a 24 hour staffed residence some five years previously. The design and location was not ideal for the age profile of residents. The staircase was steep and narrow and those with limited mobility could not manage the stairs. Some residents were at risk of falls. The smoking room was very smoky and not ventilated adequate to its function. Sleeping accommodation was mainly shared. Residents relied on the house transport or taxis to access community facilities in the town.

The rehabilitation team had responsibility for the care and treatment of residents. The ethos of the service was Recovery based. There was no written documentation available on the day of inspection in relation to the mission statement or philosophy of care operating in the residence.

Profile of residents

There were five female residents and one male resident, all of whom were voluntary and long term service users. As the age profile of residents increased so did their physical health needs. Nursing care was predominantly directed towards physical healthcare in a number of instances. The daily activity routine and community engagement of residents largely reflected their mobility and physical health status. The residence provided a relaxed caring environment to support residents.

Quality initiatives and improvements in 2012/2013

- A number of audits had been completed within the residence and the areas audited included: infection control and hand washing, fire safety, multidisciplinary individual care plans.
- A family satisfaction questionnaire was completed in 2012.
- A medication audit was completed in 2012.

Care standards

Individual care and treatment plan

There was an individual care plan for each resident. The care plans were drawn up by the resident and the multidisciplinary team (MDT). Care plans were regularly reviewed and updated. The MDT met every Tuesday at the rehabilitation outpatients department. Staff from Elm Park residence attended this meeting along with staff from across the rehabilitation services, including medium support residences, and this made for good communication and continuity of care for rehabilitation residents. Each resident met with the rehabilitation consultant on a quarterly basis or more frequently if required. The focus of care was broadly psychosocial, however, two of the six residents had significant physical health needs and this was provided by nursing staff in liaison with primary care and specialist teams, such as palliative care. Each resident had their own GP who completed six-monthly physical health reviews. Inspection of the nursing day book identified scheduled appointments for general physical reviews, and any upcoming specialist medical appointments and investigations for residents. A log book was maintained of all six-monthly physical reviews. Residents had access to national health screening programmes. The HSE funded biannual eye tests for residents. Each resident's clinical file contained an excellent resident profile sheet which summarised psychosocial profile, needs, risks, communication and social supports. This was good practice, especially where staff assigned to the resident might be unfamiliar with the service. There were excellent occupational therapy assessment reports on residents which detailed individual occupational functional capacity and highlighted appropriate rehabilitation pathways and targets. The nursing care notes were well maintained.

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

Each resident had a regular routine. Four residents attended activities outside the house and variously attended the Castle Activation Centre, the local Skills Base unit and the Dolmen Centre, all of which were Health Service Executive run services. Residents were not involved in community or voluntary groups. Residents were encouraged to be as actively involved in the household routine as possible. Some residents required significant support in activities of daily living. The housekeeping staff facilitated residents in doing personal laundry, in cleaning their rooms and in menu choices and some simple cooking. There was no housekeeping support at weekends.

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

Residents had generally been involved with and resident in mental health services for some time. Involvement with and integration into local community activities was not a strong feature of the lives of current residents. However, one resident went to the pub to watch sports each Saturday and another resident spent each weekend with family. The residence was a half mile or so outside Carlow town and residents relied on being driven by staff or paid for a taxi to access shops and the community.

Facilities

The residence did not provide single room sleeping occupancy and this was not respectful of privacy. The premises were clean and tidy at the time of inspection. The decor and furnishings was domestic and homely in style, other than the floor coverings and there was an adequate amount of seats to comfortably accommodate all residents. The housekeeping staff worked Monday to Friday and in addition to cooking meals, looked after the general cleaning and tidying. Residents were encouraged to do their own laundry and each room had personalised bed linen. The house was well maintained, however, staff reported that owing to demands on the service, there were delays in getting routine maintenance. Staff reported that there was poor regulation control of the heating system within the house and the temperature was often too warm.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
Acting CNM2	1	0
RPN	0	1

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

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	Quarterly or as required
NCHD	1	As required
Occupational therapist	1	As required
Social worker	0	Input from General Adult team if required
Clinical psychologist	0	Input from General Adult team if required

Medication

Prescribed medications for residents were dispensed by a local pharmacist. The consultant psychiatrist or non consultant hospital doctor wrote a prescription kardex for psychotropic medications. This was provided to the residents' own GP who transcribed the prescription to a medical card prescription card if applicable. The GP prescribed medicines for physical health care. Nursing staff brought the prescriptions to the local pharmacy and then collected medications on a monthly basis. No resident was on a self-medicating programme. Depot medications were administered by nursing staff within the residence. Where a resident did not have a medical card they paid medication and dispensing charges.

Tenancy rights

All residents were charged a flat rate of €75 weekly for bed and board. The house was Health Service Executive owned and there were no tenancy agreements in place for residents. There was no social fund in operation and this was good practice as it facilitated individual autonomy. All but one resident managed their own financial affairs and had their own building society accounts. Rent was paid by direct debit to the household account. One resident, who required assistance to manage personal spending money, was supported by nursing staff in this regard. An account book was maintained by the nurse in charge and was available for inspection. Other residents kept very small amounts of petty cash for personal spending. All account books were maintained within the residence and were audited on a regular basis by personnel from the HSE's accounts department in Carlow town.

Staff reported that community meetings took place very occasionally and that mealtimes provided a forum for discussing any issues arising from communal living. The inspector met with some residents during the lunchtime meal and all expressed satisfaction with living conditions and care within the house. Residents felt their views were heard in relation to items such a menu choice and being facilitated in going to the shops or other services in the community.

The complaints procedure and contact details for the independent advocacy service were posted in the dining room. The advocate did not visit the residence. There was no record of complaints as such, but the desk diary contained a record of issues arising, and it was evident that this included verbal concerns or complaints and that these were followed up and resolved. There was no incident record maintained within the residence. Any incident which occurred was entered on an incident report form and sent to the Director of Nursing. On the day of inspection staff had no knowledge in relation to incidents or outcomes.

Financial arrangements

The HSE's policy on residents' personal property and possessions applied. Staff handled petty cash and all records were audited by the HSE accounts personnel on a regular basis. The records available on the day of inspection included, household shopping, personal petty cash receipts and a record of personal spending for one resident. All records were well maintained and detailed. All but one resident managed their own monies. All residents were presumed to have capacity and there were no Wards of Court.

Service user interviews

The inspector met with those service users who were at home at the time of inspection. Interaction between residents and staff was observed to be warm and open. One retired member of staff had dropped in to support the residents in their running of their weekly lotto syndicate. Residents expressed satisfaction with the care and support provided to them. It was evident that there was an open and informal style to communication which was appropriate to the culture of the residence. In addition to information booklets, on mental healthcare, medications and services, being available, residents were comfortable in seeking information and engaging with staff. Each resident was fully apprised of their individual care plan and weekly schedule.

Conclusion

The rehabilitation team looked after the care and treatment of residents. Each resident was supported to function at their optimal level of independent living. Nursing and housekeeping staff provided the essential day to day care and were observed to have warm and open interaction with residents. The medical review of residents was excellent and timely. The fact that the rehabilitation team meeting included input from staff across the catchment area meant that there was a sharing of knowledge and communication and this facilitated continuity of care where a resident moved from one community setting to another.

The house design was not ideal from a couple of aspects as residents had to share bedrooms and the stairs were steep and hazardous to those residents at risk of falls. Due consideration ought to have been given to these aspects of care when the residence was commissioned as a community residence in recent years. Single room accommodation should be the standard in community residences.

Recommendations and areas for development

1. All bedrooms should be single occupancy.

2. A log of incidents should be maintained within the residence.

3. Only those residents with appropriate mobility should be accommodated within the residence.