Mental Health Services 2015

Inspection of 24-Hour Community Staffed Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 9
MENTAL HEALTH SERVICE	Dublin North West
RESIDENCE	Weir Home, Dublin 8.
TOTAL NUMBER OF BEDS	13
TOTAL NUMBER OF RESIDENTS	13
TEAM RESPONSIBLE	Homeless Service
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	17 February 2015
INSPECTED BY	Dr. Enda Dooley, MCN 04155, Assistant Inspector of Mental Health Services
ACTING INSPECTOR OF MENTAL HEALTH SERVICES	Dr. Susan Finnerty, MCN009711

Summary

- Weir Home was a large 24-hour nurse-staffed residence located in Dublin 8.
- The residence required significant renovation and maintenance.
- The number of residents normally accommodated in Weir Home was in excess of that recommended in *A Vision for Change* and this posed difficulties in organising a therapeutic regime to meet the needs of all the residents.
- Legal requirements in relation to the prescribing of medication must be observed.
- Individual Care Plans (ICPs) should be reviewed on a regular basis and the involvement of the resident should be apparent.

Description

Service description

Weir Home was a 24-hour nurse-supervised residence for men located in a four-storey building in Cork Street. The residence was originally built over a hundred years ago as a nurses' home for the adjacent Fever Hospital. The house has functioned in its present role for over thirty years. It provided accommodation for a cohort of homeless men who have a history of severe and enduring mental illness. The residence functioned with a rehabilitation/activation ethos. Recently discovered structural faults in the building with implications for the use of fire escapes had necessitated the relocation of a number of residents to the Phoenix Care Centre because of a number of bedrooms being too far from egress points in the event of fire.

Profile of residents

Until some months ago (see above) the residence could accommodate 17 men. This had now been reduced to 13 until the structural issues are resolved. Residents ranged in age from 40 to 73 years. The length of stay varied from six months to over 20 years. All residents were voluntary and none was a ward of court. All were fully mobile and independent.

Quality initiatives and improvements in 2014-2015

- The Activation Programme had been increased from half-day to full day.
- Development of the Doras Project (funded by Genio) had facilitated the successful movement of a number of long-term residents to independent community living.

Care standards

Individual care and treatment plan

The residence functioned on a recovery and rehabilitation ethos with specific focus on activation for residents. While clinical files contained ICPs these had usually been initiated while the residents were previously in St. Brendan's Hospital. In a number of files reviewed the ICPs showed no evidence of recent review. In a number of cases the most recent documented review was a number of years previously. There was no indication that residents were directly involved in such reviews, or were offered a copy of their ICP.

Staff indicated that the responsible consultant undertakes regular review sessions each Friday in the residence. This was generally attended by nursing staff and, if relevant, the team social worker. Staff interviewed were not aware of any formal mechanism for access to specific rehabilitation service assessment.

Formal risk assessment was undertaken and documented at the time of transfer from the approved centre or admission to the residence. Thereafter, there was no formal process for risk review and this was undertaken as deemed necessary.

Staff in the residence presented as supportive and engaged with the residents' needs. This was apparent from interaction observed during the inspection.

Physical Care

There was a regular schedule of physical reviews documented in the staff office. Six-monthly physical reviews were undertaken by the team registrar and follow-up arranged as necessary. All residents had their GP in the local area and staff indicated a good level of engagement and co-operation with the practice in relation to relevant screening programmes. Residents received regular flu vaccination from their GP. Access to specialist services such as physiotherapy was arranged through primary care as required. The residence had regular input from a chiropodist. Patients who might have hospital appointments would either attend on their own or with staff assistance, depending on the individual situation.

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

In addition to a regular activation programme provided on a 5-day basis by a dedicated activation nurse within the residence, a number of residents attended external centres for activities during the week. These were in the general locality or, in some cases, involved a bus journey across town, e.g. to attend the Basin Club in Blessington St.. The in-house activation sessions were either on a group or individual basis depending on the needs of the individual resident.

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

Residents had unrestricted access to the local community. They could go out to local shops or other amenities as they wished. The residence was located on a busy bus route which facilitated travel into the city centre. A number of residents had family members who either visited regularly or facilitated home visits or longer periods of leave.

Facilities

Weir Home was located in its own grounds. It was a narrow building, built perpendicular and adjacent to the main street. The building consisted of a ground floor and three upper storeys. Half the accommodation on the upper floors (street side) was derelict and locked. Resident accommodation on these upper floors had recently been decreased because of fire safety issues.

The overall state of maintenance of the residence was poor. External brickwork and piping was poorly maintained and internally the premises looked worn, run-down, and in need of significant renovation and maintenance. The ground floor contained an entrance area, staff office, sitting room, and separate dining room, kitchen and food storage area. The sitting room provided TV (terrestrial), radio, and a supply of books. The dining room had adequate space for residents. Food supplies were provided from stores in Cherry Orchard Hospital. The midday meal was prepared in Usher's Island day centre (about 2km away) and transported to the residence in heated containers. A weekly menu was located in the kitchen and was available to residents.

All residents had their own individual bedrooms. Bedrooms were furnished with a bedside locker and wardrobe. A number of residents had their own TV located in their bedroom. Residents did not hold a key to their rooms. In some cases residents had provided their own locks for wardrobes. It was apparent in a number of rooms that storage space was inadequate as residents were obliged to store personal property in bags on the floor. Overall, bedrooms and other personal space showed little evidence of personalisation.

Toilet and bathroom facilities were located on each of the upper floors. Shower facilities were locked and when access was requested it took some time to locate a key to these facilities. This delay could have potential implications should staff, for any reason, need to access a shower room while in use. The shower facilities reviewed were in need of maintenance and renovation. They contained a number of ligature anchor points.

Water fonts were available on all floors.

Meals

As indicated above, morning and evening meals were prepared on-site by domestic staff. The midday meal was provided from a kitchen in Ushers Island day centre. Residents did not cook their own meals and access to the kitchen was limited by the requirement for staff supervision. Residents could prepare snacks under supervision. A weekly menu was kept within the kitchen area and this was available to residents. A choice of main meal was routinely available and staff facilitated a choice of breakfast and evening meal items. Food supplies were provided by a central store in Cherry Orchard Hospital and residents did not engage in food shopping or preparation for the residence.

Staffing levels (full time in residence)

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2 (subject to roster)	1	0
RPN	1	1
Activities Nurse	1	0
HCA	0	1
Domestic staff	1	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	1
NCHD	1	2
Occupational therapist	0	0
Social worker	1	2
Clinical psychologist	1	On request

Non-Consultant Hospital Doctor (NCHD)

The responsible consultant psychiatrist undertook a regular weekly review session in the residence. This involved predominantly medical and nursing staff with input, as required, from the team social worker. The residence did not have access to an occupational therapist and access to psychology input was by specific referral.

Complaints

There was information available in public areas regarding the HSE complaints policy *Your Service, Your Say*. The residence had a nominated complaints officer who was based elsewhere. There was no complaints log kept in the residence. Staff indicated that a weekly planning meeting which was open to residents was held on Fridays. This aimed to plan activities and outings for the coming period and to consider the wishes of residents in this respect. Regular minutes of these meetings were not kept.

A formal incident report book was kept within the residence. This was inspected and was up to date with documentation regarding specific incidents and the response to these.

Medication

None of the residents were on a self-medicating programme. Medications were reviewed by the clinical team and a kardex prescription system maintained by staff. Prescriptions provided by the resident's GP would be incorporated into the kardex. Medication was obtained as stock from a central pharmacy in St. Mary's Hospital, Phoenix Park.

Prescription kardexes were reviewed and it was noted that there was a failure in certain cases for the legally required Medical Council Number (MCN) to be recorded on prescriptions.

The Residence

Weir Home was owned by the Society of Friends (Quakers) and was operated on a long lease by the HSE. Residents paid a weekly charge of €80 which included accommodation, food, and utilities. All residents paid the same weekly amount. Rent was paid by direct debit to the HSE.

Financial arrangements

All residents had their own post office or bank accounts. Staff assisted a number of residents in the management of their weekly funds. Residents' funds were held in a safe within the residence and any transactions were recorded and signed by both staff and residents. A twice daily reconciliation of funds held in the residence was maintained. There was no common social fund maintained. A small activation fund was provided by the HSE and overseen by the Activities Nurse.

Service user interviews

The inspector spoke informally to a number of residents during the course of the inspection. No resident specifically requested to meet with the inspector. No resident had any specific complaint and all were generally favourably disposed towards the residence.

Conclusion

Weir Home was a 24-hour nurse-staffed community residence located in Dublin 8. It catered for a cohort of men with a history of severe and enduring mental illness. There was a positive relationship between staff and residents. The residence was in a poor state of repair, which was regrettable, given the location and potential of the site. There were external smoking and garden facilities available to residents. There was a positive emphasis within the residence on activation and community engagement. This focus had assisted in maximising the potential of the residents within the therapeutic resources available. It was disappointing that residents were not facilitated or encouraged to cook and cater for themselves domestically within the residence. The capacity of the residence was in excess of that recommended in *A Vision for Change*.

Recommendations and areas for development

1. *The residence should have significant renovation and upgrading to maintain its utility as a suitable high-support community residence.*

2. *Consideration should be given to a structural re-organisation so that the capacity of the facility is more in keeping with the recommendations of 'A Vision for Change'.*

3. *Any renovation should seek to address and minimise potential ligature anchor points.*

4. *To minimise potential risk, it is essential that staff have ready access to the means to override any room which may be locked by residents. This should take due account of the right to privacy of the residents.*

5. *Prescribers must include their Medical Council Registration Number in all prescriptions as required by legislation.*

6. *Residents should have regular review of their Individual Care Planss and this review should involve all members of the Multi-Disciplinary Team.*