INSPECTORATE OF MENTAL HEALTH SERVICES

A REVIEW OF 24-HOUR SUPERVISED RESIDENCES 2009-2013

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INTRODUCTION

The 1984 report on psychiatric services *Planning for the Future* recommended the development of 24-hour staffed high support hostels for patients who could be relocated from psychiatric hospitals. It stated that these patients would have long term mental illness but could live in the community. They would be living apart from their families due to psychiatric illness. The hostels were mainly seen as residences for new long stay patients.

Since then there has been a growing number of 24-hour supervised residences which, over time, have been increasingly used for relocating long-stay residents from hospital wards into the community, enabling the closure of long-stay wards and hospitals. Also "significant numbers of long-stay service users, particularly the elderly and people with intellectual disability were discharged through de-designation, a process which re-categorised the facility in which they were living as no longer being part of the mental hospital" *(A Vision for Change 2006).* Residents in these de-designated units formed part of the population of service users living in 24-hour supervised residences.

A Vision for Change stated that these community residences were often little more than replacements for long-stay wards in their size and absence of rehabilitation programmes. It recommended that 24-hour supervised residences should have a maximum of 10 places to foster a non-institutional environment and that nursing staff in these residences should be predominantly involved in therapeutic activities with residents rather than with domestic or administrative activities. *A Vision for Change* also recommended that rehabilitation and recovery teams should have responsibility for those physical resources appropriate to the needs of their service users such as community residences. Therefore, access to fully resourced rehabilitation teams (psychology, occupational therapy, social worker, psychotherapy) should be available as well as access to day centre, training and vocational agencies. *A Vision for Change* also made the observation that the need for 24-hour staffed residences would decrease once the cohort of former long-stay hospital service users had been provided for.

In 2005 the Inspectorate inspected all 24-hour supervised residences under the care of the mental health services, of which there were 127. The list of these residences was provided by the Health Service Executive.

The main findings of inspections of these 24-hour supervised residences in 2005 were:

- There were approximately 1700 residents in 24-hour supervised residences.
- There were only a small number under the care of rehabilitation and recovery teams (only six teams nationally).
- There was a lack of available accommodation for residents who were ready to be discharged from 24-hour supervised residences.
- The majority of residences were too large, having up to 20 residents, some with up to 30 residents.
- A significant number were located in isolated areas.
- There was little input from the multidisciplinary team.
- Establishment of these residences was related to hospital closure rather than rehabilitation.
- In conclusion, the majority were long-stay wards in the community.

It was difficult to ascertain accurately the number of 24-hour supervised residences nationally in 2013. The Mental Health Division Operational Plan 2014 states that there are 102 “high support residences”. It was estimated by the Inspectorate that there were one hundred and fifteen 24-hour supervised residences nationally in 2013, a decrease since 2005 (127 residences).

METHOD OF REVIEW

Since 2009, the Inspectorate had inspected a number of 24-hour community residences throughout the country. For the purpose of this report, the inspection reports from 2009 to 2013 were collated. This gave a total of 83 residences inspected between 2009 and 2013. This provided a representative sample of the 24-hour supervised residences nationally.

This reports looks at (1) the description of the residences and (2) the care and treatment received by the residents.

There are no regulations, guidelines or codes of practice in relation to 24-hour supervised residences. The Inspectorate used the Quality Framework[1] to guide its inspections.

[1] Quality Framework for Mental Health Services in Ireland 2007, Mental Health Commission

DESCRIPTION OF RESIDENCES

Number of beds

The number of beds in the 83 inspected 24-hour supervised residences varied considerably, ranging from three beds to 32 beds. *A Vision for Change* recommended that "these residences should have a maximum of 10 places to foster a non-institutional environment". In the sample of 83 residences, just over one quarter of 24-hour supervised residences had the recommended number of residents as outlined in *A Vision for Change*. One third of 24-hour supervised residences had between 11 and 15 beds. However 38% had more than 15 beds with six residences having more than 25 beds.

Table 2: Number of beds

Number of beds	Number of Residences	Percentage of residences
10 or less	23	28%
11-15	28	34%
16-20	20	24%
21-25	6	7%
>25	6	7%
Total	**83**	**100%**

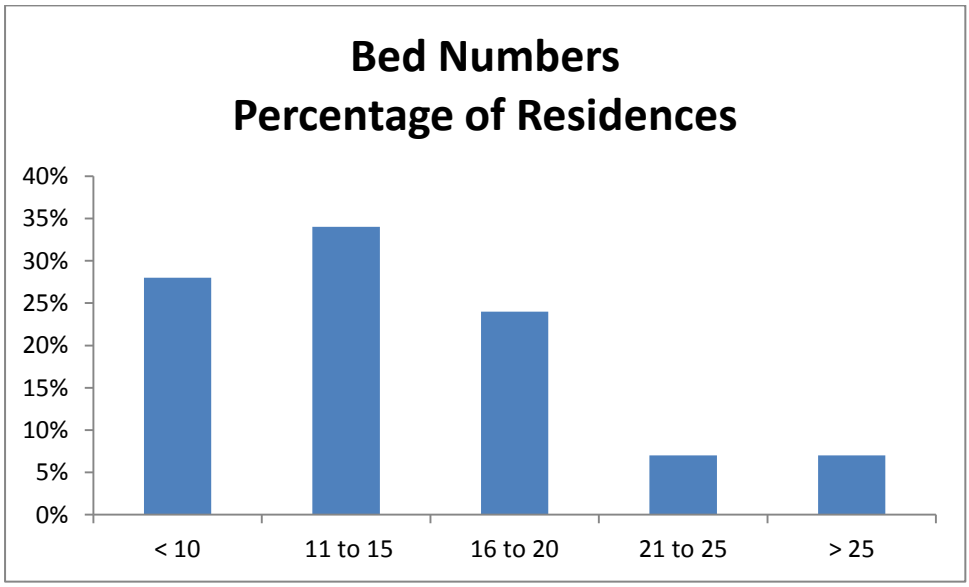

Chart 1: Number of beds in residences

Location of residences

The location of 24-hour supervised residences is important. If a residence is in a remote location there are fewer opportunities for residents to belong to the local communities and to avail of facilities such as coffee shops, pubs, library, shops and cinemas. Many residences have access to a mini-bus or people-carrier but this means that residents are reliant on staff to access community facilities. It is important to note that a small number of residents expressed a liking for living in a rural area.

Seventeen per cent of inspected residences were in remote or isolated locations and had limited opportunity to access community facilities. A further 17% of residences were located in hospital grounds, either the grounds of psychiatric hospitals or community hospitals. This increases the risk of stigmatisation and separateness from the community. Two thirds of residences were located where community facilities could be easily accessed.

Table 3: Location of residences

	Number of residences	Percentage of residences
In grounds of hospital (general/psychiatric)	14	17%
Embedded in community	55	66%
Isolated/outside town	14	17%

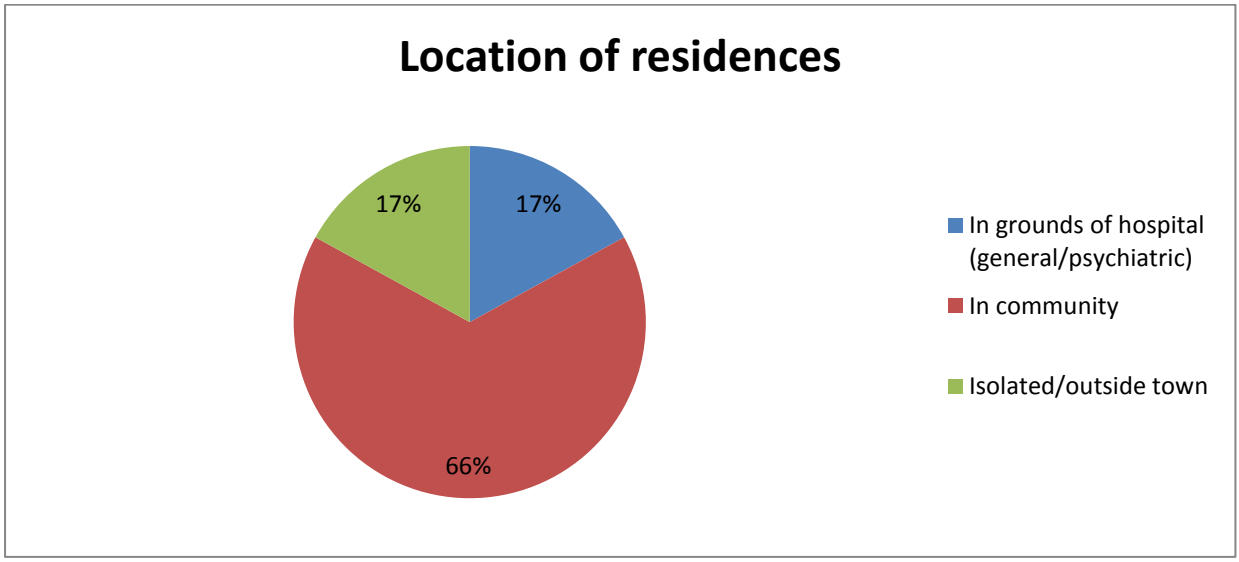

Chart 2: Location of residences

Tenancy

The vast majority of the 83 residences (88%) were owned by the Health Service Executive (HSE). Five were owned by the Mental Health Association, two were leased from private individuals and two were owned by housing associations.

The HSE charges long-stay residents as outlined below:

Charges Applicable as per HSE. Website 25.01.13

Long-stay patients

"Health Regulations came into effect on 14th July 2005 which stated that Charges may be imposed on long-stay or extended care patients in HSE public care, up to a maximum of €175.00 per week. The Regulations provide for different charging arrangements, depending on the level of nursing care being provided.

Class 1: those receiving in-patient services in premises where nursing care is provided on a 24 hour basis. Maximum weekly charge for care will be €175.00, or their weekly income less €44.70, whichever is the lesser.

In certain circumstances the Health Service Executive has the discretion to alter charges in order to avoid hardship.

The Regulations (S.I. No. 276/2005 — Health [Charges for In-Patient Services] Regulations, 2005) apply to any person in a premises receiving 24-hour nursing care on those premises"

In the sample of 83 residences in this report the rent that residents paid varied greatly between different residences. Rent did not appear to be dependent on location, size or staffing of the residences. The range was from less than €50 per week to more than €120 a week. In all cases, the rent recorded included bed, meals and utilities. No reason was evident for this variation.

Table 4: Rent (including board)

Rent	Number of residences	Percentage of residences
<€50	1	1%
€50-60	13	16%
€61-70	11	13%
€71-80	18	22%
€81-90	6	7%
€91-100	11	13%
€101-110	5	7%
€111-120	6	6%
>€120	5	7%
Means tested	7	8%

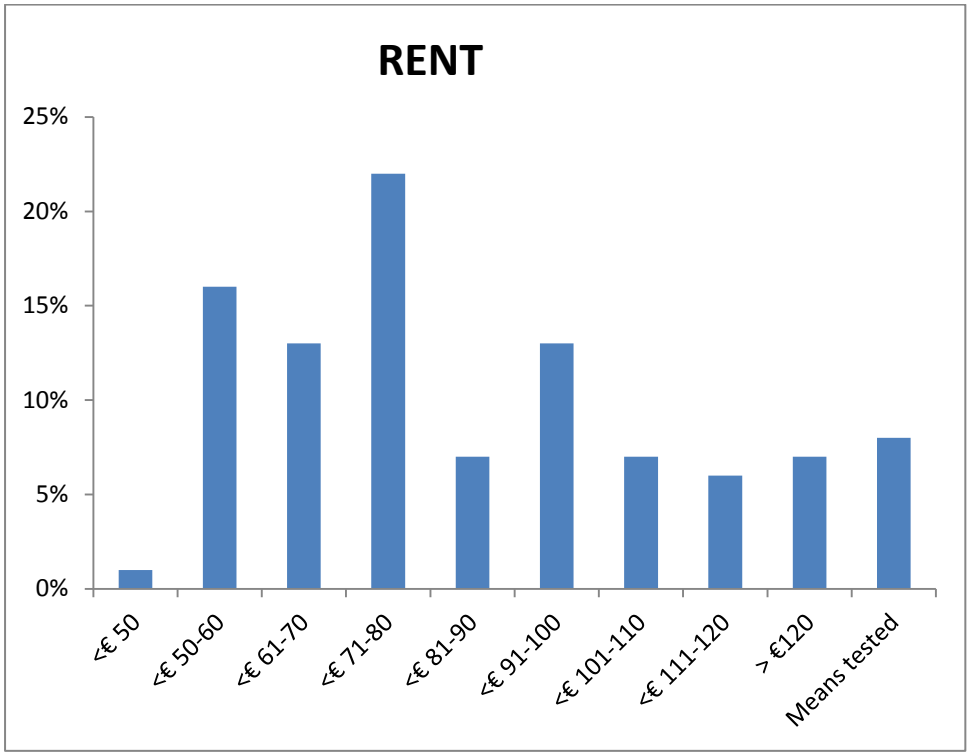

Chart 3: Rent

Maintenance of residences

Maintenance was good or satisfactory in 77% of the 83 residences. In most residences there was easy access to maintenance and the premises were well decorated and furnished. It was evident in all but a small number that efforts had been made to make the environment homely. Twenty-three per cent of the residences inspected were poorly or very poorly maintained. In some, bathrooms were in poor condition. In others paint work was peeling, there were damp patches, floor coverings were dirty or needed replacing and gardens required maintenance.

Table 5: Maintenance

Level of Maintenance in Residence	Number of residences	Percentage
Good	47	57%
Satisfactory	17	20%
Poor	13	16%
Very poor	6	7%

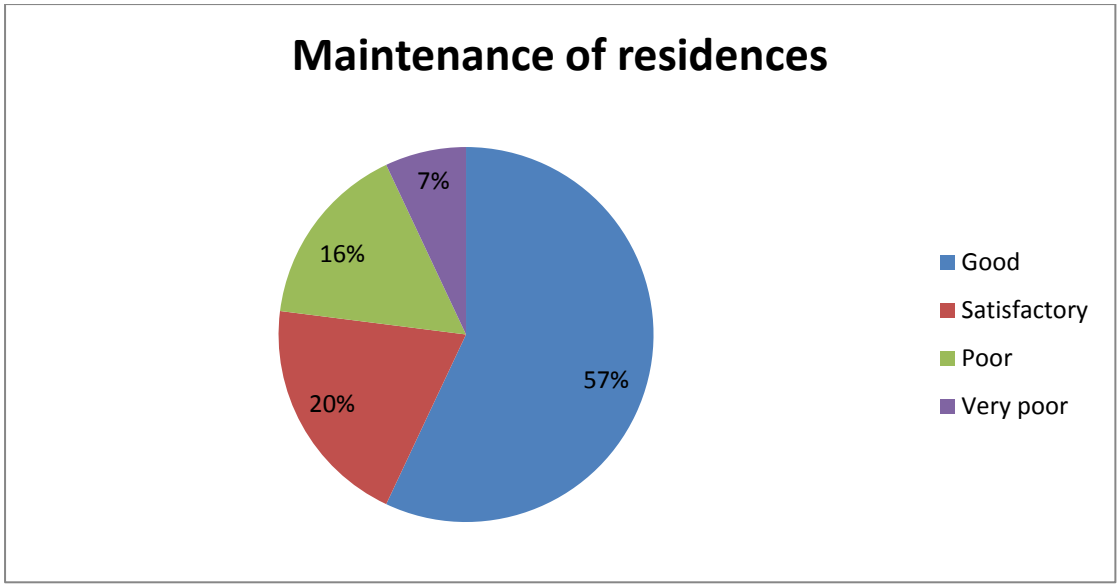

Chart 4: Maintenance of residences

CARE AND TREATMENT OF RESIDENTS

Responsible Clinical Team

Forty-six per cent of inspected 24-hour residences were under the clinical care of a rehabilitation team. Forty-six per cent of residences were under the care of a general adult community mental health team, usually within a sector. In a small number (four) both the rehabilitation team and sector team each had responsibility for a designated number of beds in the residence.

Table 6: Responsible clinical team

Responsible Clinical Team	Number of residences	Percentage
General Adult	38	46%
Recovery and Rehabilitation	38	46%
Shared	4	5%
Other (ID, POA, Homeless)	3	3%

ID: intellectual disability; POA: psychiatry of old age

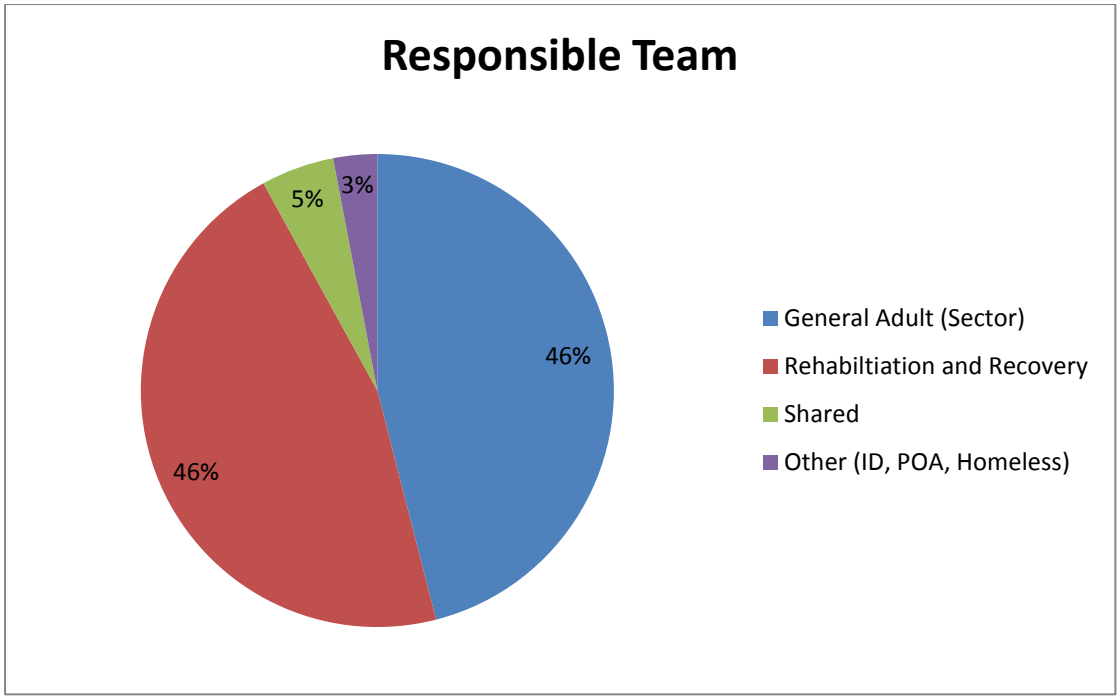

Chart 5: Responsible clinical team

Access to Health and Social Care Professionals

The overall access to occupational therapy and psychology was poor. Just over half of residents had access to occupational therapy and psychology and just under two thirds had access to a social worker.

Table 7: Overall Access to MDT

Access to MDT	Number of residences	Percentage
Occupational therapy	48	58%
Social work	52	63%
Psychology	46	55%

There were differences in access to health and social care professionals depending on whether the residence was under the care of a general adult sector team or a rehabilitation team. Residents were more likely to have access to social work and psychology if they were under the care of a general adult team. However, more residents had access to occupational therapy if under the care of a rehabilitation team. This probably reflects the availability of multidisciplinary staffing in different mental health teams.

Table 8: Access to MDT by clinical team

	Occupational Therapy	Social Work	Psychology
Rehabilitation Team	65%	55%	43%
Sector (General Adult) Team	52%	67%	63%

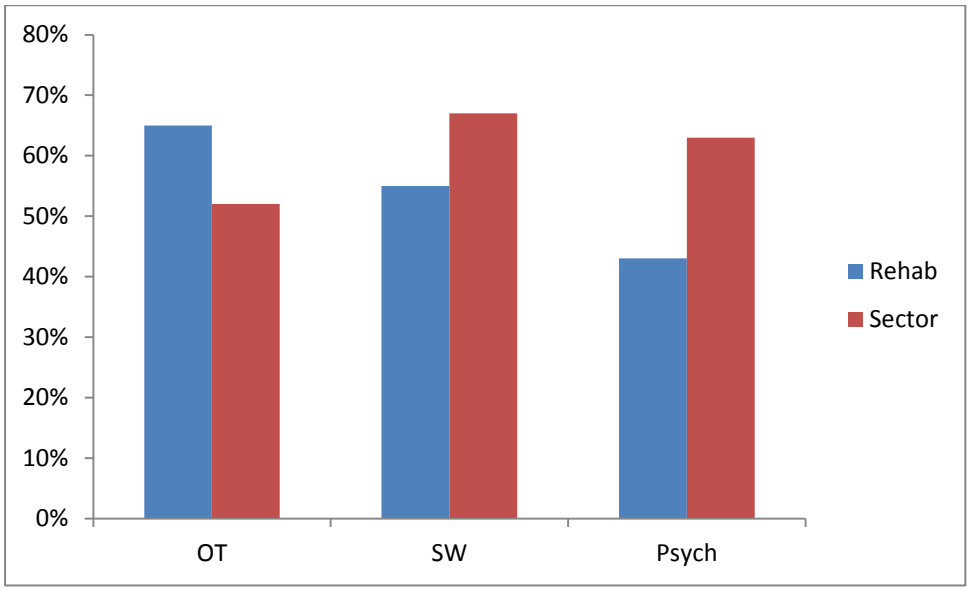

Chart: 6 Access by residents to MDT

Nurse and Health Care Assistant Staffing

In residences with ten or fewer beds, the number of nurses and health care assistants on duty during the day varied between one staff member (six residences) to three staff members (five residences). In the larger residences (11 to 20 beds), the number of staff during the day varied between one staff member (six residences) and four staff members (four residences). In residences where the number of beds exceeded 25, the number of nurses varied between two nurses and seven nurses.

At night 64% of residences had either two or three staff members on duty. Twenty eight (34%) residences had only one staff member on during the night and 13 (46%) of those residences had between 11 and 20 beds. Two residences had four staff members on duty at night; these had in excess of ten beds.

Table 9: Nurse and HCA staffing levels by day

Day staffing	Residences with 10 or less beds	Residences with 11-20 beds	Residences with more than 20 beds
1 x Nurse/HCA	**6**	**6**	**0**
2 x Nurse/HCA	**11**	**16**	**2**
3 x Nurse/HCA	**5**	**19**	**5**
4 x Nurse/HCA	**0**	**4**	**7**
> 5 Nurse/HCA	**0**	**0**	**2**

Table 10: Nurse and HCA staffing levels by night

Night staffing Nurses/HCA	Residences with 10 or less beds	Residences with 11-20 beds	Residences with more than 20 beds
1 x Nurse/HCA	**15**	**13**	**0**
2 x Nurse/HCA	**10**	**27**	**10**
3 x Nurse/HCA	**0**	**2**	**4**
4 x Nurse/HCA	**0**	**1**	**1**

Psychiatric Care

The majority of residences (79%) were visited at least every six months by a consultant psychiatrist. A number of teams held monthly multidisciplinary team meetings. The staff in four residences stated that a consultant psychiatrist never visited the residence.

Non consultant hospital doctors (NCHDs) varied in how often they reviewed residents. Thirty-eight per cent reviewed residents weekly, while 29% visited the residence on request only. In six residences there was no NCHD assigned to the residence and the staff depended on the NCHD on-call to respond.

Table 11: Psychiatric Care by consultant psychiatrist

	Number of residences	Percentage
Consultant Psychiatrist review:		
Within 6 months	66	79%
More than 6 months	13	16%
Never	4	5%

Table 12: Psychiatric care by NCHD

NCHD attendance at residence	Number of residences	Percentage of residences
Weekly	31	38%
2 weekly	5	6%
More than 2 weekly	17	20%
On request	24	29%
No NCHD on team	6	7%

Care plans

In the inspection in 2005, very few residents had multidisciplinary individual care plans. In the sample of residences inspected between 2009 and 2013, over two thirds of residents had multidisciplinary care plans that were regularly reviewed and had service user input. Twenty-four per cent had nursing care plans only, with no input from the multidisciplinary teams. In six residences the residents had no care plan at all.

In 81% of residences which were under the care of a rehabilitation team, residents had an individual multidisciplinary care plan. Only 24% of residences which were under the care of a general adult team had individual multidisciplinary care plans for residents.

Table 13: Care plans

Care Plans	Number of residences	Percentage of residences
MDT care plans	57	69%
Nursing care plans only	20	24%
No care plans	6	7%

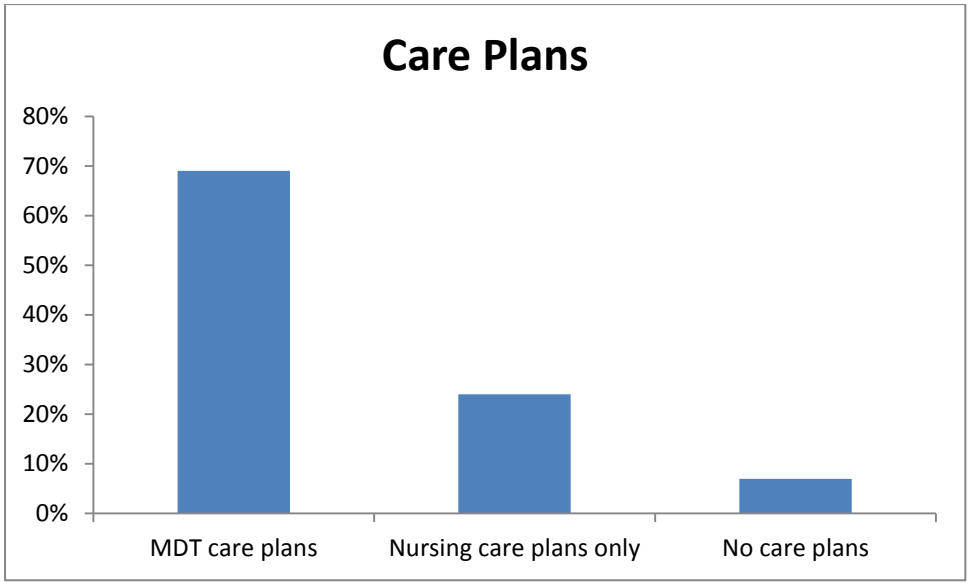

Chart 7: Care plans

Activities

In the majority (82%) of residences residents attended outside activities. These included open employment, sheltered workshop, training centre or day centre. Some residents attended educational and vocational training. Despite the access to occupational therapists in 58% of residences, only 11% of residences had structured occupational therapy programmes within the residences. However, nursing staff in 46% of residences did provide activities which included relaxation, newspaper reading, community meetings, money management, cookery and daily living skills. Only seven per cent of residences had no activities for residents either inside or outside the residence.

Table 14: Activities

Activities	Number of residences	Percentage
Attended other facilities	68	82%
Provided structured activities within residence	38	46%
Occupational therapy input	9	11%
No structured activities	6	7%

CONCLUSION

Twenty-four hour nurse supervised residences house some of the most vulnerable and long-term mentally ill service users and have a large number of nursing staff employed within them. The Inspectorate has consistently found it difficult to ascertain correctly the number of these residences nationally. As such, there appears that there is no definitive list of 24-hour nurse supervised residences available.

The concern in 2005 that 24-hour supervised residences were too big remained a concern in 2013. Seventy-two per cent of residences had more than ten residents, ten being the maximum number of residents recommended by *A Vision for Change.* Some residences are very large with over 20 beds. It appears that in some cases whole long-stay wards were transferred to large buildings in order to speed up the closure of psychiatric hospitals. It is difficult to see these residences as anything but wards in the community with all the disadvantages of institutional care. Added to this was the fact that some of these larger residences remained within a hospital campus, sometimes the psychiatric hospital from which the residents were discharged. It was encouraging to see some smaller residences located in the community functioning as homes where the residents were integrated with the local community.

There were a small number of residences where the condition of the building was poor or very poor. In these cases regular maintenance seemed difficult to obtain and residents were left living in very poor conditions.

The differing amounts of rent paid in each residence were difficult to understand. A range from €50 a week to over €150 does not appear to be equitable. Standardisation of charges by the HSE would be fairer to the residents.

It was very encouraging to see multidisciplinary individual care plans implemented in two thirds of residences. Where rehabilitation teams had responsibility for residences, 81% had implemented individual multidisciplinary care plans, whereas only 24% of residences under the responsibility of general adult teams had implemented individual multidisciplinary care planning. This would suggest that person-centred care is superior in residences that are under the clinical care of a rehabilitation team. Access to health and care professionals remained limited. A small number of residences had minimal input from psychiatrists and NCHDs. Other residences had monthly multidisciplinary team meetings.

For most residents there was availability of activities outside the residences either through day centres, vocational training or education. The nursing staff in some residences provided therapeutic and recreational activities and in most cases the residents availed of community facilities.

Although most residences are too large, overall the care and treatment of residents in 24-hour supervised residences has improved since 2005 and it appears that the major factor influencing this improvement has been the move of clinical care to rehabilitation teams and the consequent implementation of individual multidisciplinary care planning.

REFERENCES

Planning for the Future 1984

A Vision for Change 2006

Annual Report of the Inspector of Mental Health Services 2005

Happy Living Here: A survey and Evaluation of Community Residential Mental Health Services in Ireland: MHC & HRB 2007

Quality Framework: Mental Health Services in Ireland, Mental Health Commission