Mental Health Services 2012

Inspection of 24-Hour Community Staffed Residences

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Cork, Kerry
HSE AREA	HSE South
MENTAL HEALTH SERVICE	Kerry Mental Health Service
RESIDENCE	Cherryfield House
TOTAL NUMBER OF BEDS	15
TOTAL NUMBER OF RESIDENTS	15
NUMBER OF RESPITE BEDS (IF APPLICABLE)	0
TEAM RESPONSIBLE	Rehabilitation and Recovery
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	22 November 2012

Summary

- Cherryfield House an architect-designed residence was opened in 2012, with greatly improved facilities for residents who had previously lived in an older residence which was in poor condition.
- The complaints system was not on display and no record of complaints was kept.
- Although CCTV was in use there was no signage. Consideration should be given to discontinuing its use.
- The multidisciplinary team was under-resourced and should be completed in accordance with A Vision for Change. There were no occupational therapists attached to the rehabilitation team and only limited access to social work and psychology. As a result existing staff were inhibited in the range and extent of the rehabilitative services they could provide.

Description

Service description

Cherryfield House was a single storey architect-designed continuing care residence opened in 2012. It was modern in appearance with good use made of natural light. Situated just outside the gates of St. Finan's Hospital on the outskirts of Killarney town, it was owned by the Kerry Mental Health Association and managed by staff from the HSE. Furnishings were modern and bright.

It replaced a pre-existing residence which was old and unsuitable for use as a modern mental health care facility.

Profile of residents

There were eleven female and four male residents one of whom was a part-time resident. All except one were voluntary. Their ages ranged from 32-82 years. Staff reported that all were mobile and independent and they attended day support services. There was a need for more activities in the residence to keep people occupied.

Quality initiatives and improvements in 2011/2012

- Staff reported that service users had made the transition from the old residence successfully.

Care standards

Individual care and treatment plan

All residents whose clinical files were examined had multidisciplinary individual care plans (ICP). Staff reported that residents could get a copy of these ICPs but there was no place on the documentation to record whether or not this had happened. The ICPs were reviewed six-monthly by the multidisciplinary team (MDT) and evaluated in the clinical notes between each review. Attendance at the MDT was recorded in the ICPs.

The residents were under the care of a consultant psychiatrist in rehabilitation.

Access to MDT members was limited as the rehabilitation team was under-resourced. There were few formal risk assessments in the clinical files. Staff reported these were not automatically done, but only as they felt they were needed. No resident in the three clinical files reviewed had a risk assessment in 2012. Staff reported they did have some concerns regarding risk. In one instance the nursing staff had not had access to a forensic report although this had been requested.

All the clinical notes were contained in one clinical file and were sequential.

All residents had their own general practitioners (GPs) and attended their doctors' surgeries for physical care as needed. Staff reported that the residents had good access to their GPs who conducted six-monthly physical reviews. There was evidence in the clinical files examined that physical conditions had been investigated. Psychiatric medications were prescribed by the psychiatrists.

Some policies were out of date and not specific to the residence. Some were not signed.

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

The residents attended the nearby Lime Grove day centre until noon each day where they could partake in a wide range of activities including groups, music, cooking and art. The Inspectorate was informed that specific rehabilitative and vocational training took place in Lime Grove in the afternoons, in accordance with residents' care plans. Some residents attended the rehabilitation services in Tralee or attended classes in the community according to their interests.

Although there was a modern HACCP (Hazard Analysis and Critical Control Points) compliant kitchen in the building, residents could not access this for activities of daily living. A separate kitchenette was available for making tea. It had a microwave but no cooker. Staff said they would like to be able to do more with the residents in the house in the afternoons. In particular they would like the kitchenette to be reorganised so that it would facilitate cookery classes or training in the activities of daily living over and above what residents did elsewhere.

Staff reported they had access to a bus and took the residents for outings regularly. Knitting and DVDs are organised for the evenings.

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

Some residents attended the local gym, some attended classes in the town. Others liked shopping and were facilitated in doing this themselves. Others liked walking, some occupied themselves knitting. One resident was working. Staff reported residents attended the cinema about twice a week.

Staff reported there was little support of residents being involved in the community. While the Mental Health Association did help elsewhere it seemed they were not involved with Cherryfield House. On reflection, staff agreed they may not have been asked. Staff agreed extra funding would facilitate with the organisation of events e.g. barbeques during the summer.

There was no information on notice boards about local organisations or events.

Facilities

The building was of modern design, was bright and airy and was well maintained. All residents had their own rooms and ensuite bathrooms which were spacious and clean and personalised in many instances. All had their own wardrobes, chest of drawers and a lockable drawer. Furnishings were of a high standard. The sitting and dining areas were bright and comfortable.

Staff reported that a problem with the under floor heating had arisen and there was a delay in addressing it. It was too warm in some rooms and too cold in others. It could not be regulated. It was of such a degree that one resident had to sleep with her door open at night.

A computer room was provided but just one computer was available and the room was underused as a result. Access to the internet was being considered for residents.

Staff reported they had limited access to the internet on a separate PC. They could not browse information on mental health. They could not access online phlebotomy reports, but had to physically collect these for team meetings.

Residents did their own laundry in the laundry room provided.

CCTV was used in the residence, but there were no notices displayed to this effect.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
RPN	2	2 (1 shared with group homes)
Housekeeping	1	0
Cook	1	0

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

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	1 weekly
Senior Registrar	1	Weekly or as needed
Occupational therapist	0	0
Social worker	0.5	As needed
Clinical psychologist	0.3	As needed

Medication

A staged programme of medication administration was in place. Residents could administer their own medication using blister packs if agreed with MDT. Depots were administered by nursing staff. Kardexes were legible but doctors did not use their Medical Council Number (MCN) when writing prescriptions. Several of the prescriptions were out of date, with some having been written in 2009. No resident was prescribed a regular benzodiazepine and only one resident was prescribed a benzodiazepine 'as required' (PRN). All residents except one were prescribed an antipsychotic medication and of those on antipsychotic medication, 67% were on more than one antipsychotic medication. No resident was prescribed Lithium.

Staff reported that information on diagnoses and medications was available to residents in the hostel.

MEDICATION

NUMBER OF PRESCRIPTIONS:	13	%
Number on regular benzodiazepines	0	0
Number on more than one benzodiazepine	0	0
Number on PRN benzodiazepines	1	8%
Number on benzodiazepine hypnotic	0	0
Number on non benzodiazepine hypnotic	2	15%
Number on PRN hypnotic	2	15%
Number on antipsychotic medication	12	92%
Number on high dose antipsychotic medication	3	23%
Number on more than one antipsychotic medication	8	62%
Number on PRN antipsychotic medication	6	46%
Number on Depot medication	6	46%
Number on antidepressant medication	6	46%
Number on more than one antidepressant	1	8%
Number on antiepileptic medication	5	38%
Number on lithium	0	0

Tenancy rights

Staff reported that residents had been interviewed by the Mental Health Association prior to their admission when the house opened. At that time a tenancy agreement was signed, so that residents had a right to remain in the house so long as they kept to the terms of their agreement. However, the residents did not have a copy of the agreements.

The rent was €106 per week, inclusive of food. Staff reported residents had approximately €60 remaining from their social welfare allowances.

Community meetings took place monthly to discuss issues that might have arisen in the house. Staff reported this often had to do with complaints about the food.

No record of complaints was kept. The complaints procedure was not used to address issues that were highlighted at the monthly meetings, or to address issues to do with the under-floor heating. There were no leaflets about the complaints procedure on display.

Financial arrangements

All residents had their own bank accounts and rent was paid by means of direct debits. Where residents had cash it was kept in a locked press in the nursing office. Each person had their own account book and records of withdrawals made were signed by both nurse and resident.

Service user interviews

A number of residents were interviewed on the day of inspection and professed themselves to be happy with the service. They commented on the quality of the building and one said it ‘was like a hotel’.

Conclusion

This residence was a beautifully designed modern facility which gave residents access to their own ensuite facilities which many had personalised for their own use. As it was single storey it was well placed to facilitate residents who were getting older.

It was within easy reach of the town and residents were able to take advantage of this. Residents were able to access facilities in the town, but there was limited information available about local groups or organisations which might be of help to them in this regard.

Care and treatment was provided by a consultant psychiatrist in rehabilitation and by an under-resourced multidisciplinary team. There was no access to an occupational therapist and limited access to social work and psychology.

Two RPNs were rostered for duty in the residence during the day and at night. However, the Inspectorate was concerned that the second nurse during the night could be required for duties elsewhere, leaving just one member of staff alone with fifteen residents.

All residents whose clinical files were reviewed had a multidisciplinary individual care plan which was reviewed on a six-monthly basis and evidence of it being evaluated between reviews was available in the clinical files.

Staff were dissatisfied with the activities available for residents within the house.

Recommendations and areas for development

1. *Signage should be erected regarding the use of CCTV. Consideration should be given to discontinuing the use of CCTV within the residence.*

2. *Risk assessments should be conducted periodically for all residents.*

3. *The multidisciplinary rehabilitation team should be completed in accordance with the recommendations of A Vision for Change.*

4. *Two dedicated members of staff should be on duty in the residence at night.*

5. *The complaints system should be displayed and the complaints officer should be identified. A complaints record should be kept. The complaints system should be used to highlight issues that cannot be resolved at a local level.*

6. *A functioning kitchen should be available to residents for activities of daily living.*

7. *Residents should have a copy of their tenancy agreements.*

8. *Heating problems in the house should be addressed.*

9. *Information should be provided on local organisations and activities that would be of interest to residents and residents should be encouraged in this regard.*

10. *Doctors should use their MCN when writing prescriptions.*

11. *All prescriptions should be in date.*