EVALUATION OF A HOME CARE SERVICE FOR PATIENTS WITH ACUTE MENTAL ILLNESS
IN DUBLIN SOUTH EAST MENTAL HEALTH SERVICES

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1. SUMMARY

The Irish Government, in the Vision for Change policy document, has proposed that specialist multidisciplinary community-based teams are established in order to meet the needs of clients, families and carers (Department of Health and Children 2006). As a direct response to these government directives, Dublin South East Mental Health Services established an Assertive Community Treatment Team known as Réimse Home Care as part of their community services. The service commenced in March 2009 and the present study aims to evaluate Réimse Home Care six months after setting up. The study is based on an audit of all documentation used by Réimse Home Care Service conducted to determine whether the agreed policies and guidelines were being implemented. Furthermore, Patient Satisfaction Survey Questionnaires (n = 21) were returned by clients who had received treatment and care from Réimse. Additional data was gained through a focus group involving the staff assigned to Réimse Home Care Service.

The results of the study suggest that there is overall satisfaction with the service, as indicated by clients who have used the service. The audit of documentation shows that in the majority of areas, the service is operating as proposed. However, it is evident both from the results of the audit, the results of the survey questionnaire and analyses of the focus group discussion that there are areas that present challenges. Clearly, there are issues that need to be addressed in future service developments in order that the service best meets the needs of the client group it serves. Identified issues include interdisciplinary/multidisciplinary approaches to treatment and care, a review of the client group being referred, and the purpose of referral of clients. Further recommendations for future service planning included information regarding medication as well as a more seamless service approach to delivery.
2.1 Background to the Project

It has long been recognized that hospitalization contributes to loss of independence and skills for people with a psychiatric illness thus adding to their level of disability (Fell & Sweeney 2007). Repeated hospital admissions are mainly due to multiple factors including severity of the illness, non-compliance with medications and the type of aftercare and support provided (Fontanella 2008). A recent report by the Irish Health Research Board (HRB) suggests that 72% of all admissions are re-admissions to psychiatric units/hospitals (Health Research Board 2007). As a result, government policy has sought to reduce the number of hospital in-patient beds available for mental health care by redirecting resources to community based services. In terms of recovery, this allows people to receive treatment in their own home and to hopefully lead more independent lives (Mental Health Commission 2008). Therefore, the focus and locus of care should be based in the community (Malone et al. 2007).

Hospitalization figures for Ireland in 1981 stood at 415/100,000 population (Walsh 1988). However, in 2007, hospitalisation rates per 100,000 of population to Irish psychiatric hospitals were 488/100,000 (HRB 2008). Even allowing for increases in population, this would suggest, in Ireland, there remains very little shift away from in-patient care towards community based care in the past quarter of a century. Indeed admission rates have risen in 2007, according to the figures published by the Government (Health Research Board 2007).
The Irish College of Psychiatrists (2004) caution that assertive community treatment is "labour intensive and expensive" and can only be justified if targeting high need/users of the services. Marshall & Lockwood (2000) support the idea that if assertive community treatment is targeted at high users of in-patient care it can lead to cost reduction and improved outcomes as well as increased client satisfaction with services. Commander et al (2005) postulate that while in-patient beds are necessary, home care may prevent hospital admission by up to 60%. This in turn may reduce disadvantages associated with admission to psychiatric wards that may include emotional trauma, stigma and a "revolving door" effect.

In the UK, Burns & Firn (2002) commented on "user led" research carried out by the Sainsbury Centre for Mental Health. The study found that home care was a more satisfactory form of care by clients and their families for a number of reasons. Firstly, participants valued the relationship with staff, which they described as "more authentic." They also appreciated the reliability of their worker who they felt offered practical help. Additionally, in an evaluation of home-based mental health services in North Kildare, the authors summarized a number of benefits in relation to home-based care. They suggest that admission rates fell by 25% (in the least effective service) and up to 60%, in the more effective services reviewed. They highlighted a decrease in length of stay as well as a reduction in trauma for the patient when admitted and a reduction in exposure to social stigma. They also state that home care was "greatly preferred by patients" (Gibbons et al 2006).

According to Smyth et al (2000), satisfaction with the service is recognized as an important factor in the recovery process with "significantly higher rates of service retention when compared to standard in-patient treatment." Furthermore, it is seen as a predictor of the client’s willingness to remain in touch with the service (Fitzpatrick 1991). Consequently, a decision was taken to include the client’s satisfaction level with the service as an important outcome to be evaluated in the present study. In order to achieve this, a revised version of the Consumer Survey on Satisfaction with Services (adapted with permission from Gerber & Prince 1999) was posted to all clients who had received care from the Réimse Home Care Service in the first six months of operation.

While community services are being developed in Ireland, initiatives have focused on Day Hospitals, Day Centres and Community Residences (Fell & Sweeney 2007). Cavan/Monaghan Services introduced Home Care Teams as an integral part of their service, which was phased in from 1998 2001 (Fell & Sweeney 2007). Dublin South West Mental Health Services were the first to set up Home Care in the Clondalkin area known as The Clondalkin Project in 1991. The Service in Dublin South West has continued to develop Home Care Services with well organised Home Care Teams coupled with a Day Hospital in each sector area.
Mental Health Services Dublin South East delivers a continuum of psychiatric services to a population of 110,000 people aged 18-65 in the Dublin City catchment area. The psychiatric services are sectorised in one of four catchment areas, each with a general psychiatry consultant responsible for the under 65 year-old population. While community facilities comprising of consultant-led sector multidisciplinary teams, community hostels, day centres and a day hospital exist, the service had no Home Care Treatment Teams.

The setting up of the Assertive Community Treatment Team (known as Réimse Home Care) followed the re-configuration of resources as a good practice initiative in line with the government stipulations presented in A Vision for Change (Department of Health & Children 2006). Consequently, in-patient beds were reduced in Elm Mount Approved Unit, St Vincent’s Hospital, and nursing staff redeployed to establish and develop the Réimse Home Care Service.

Assertive Community Home Care offers an alternative to in patient treatment and care and, whilst it is recommended as a positive way forward, existing literature provides little information on the type of patient suitable for this type of care. Harrison et al (2001) found that 48% of people referred to home treatment services were unable to use the service mostly due to an unwillingness to use the services or inability to access the services offered. Others were not considered suitable on the grounds, that they were not sufficiently “acutely ill” or considered “too unwell.” The investigators also found that 20% of patients referred to and using the service required in-patient care later.

Gibbons et al. (2006), in their review present a number of studies where the diagnosis of clients accepted for home care is outlined. They refer to home care studies undertaken in Manchester (Harrison et al 2001) and Herfordshire (Brimblecombe & O’Sullivan 1999). In each of the studies, the client illness profile was examined. The majority of clients had a diagnosis of Schizophrenia, Depression and Bi-polar Disorder. The number of clients requiring hospital admission ranged from 11-16% in these studies.
3. HOME CARE SERVICE

The literature reviewed previously, suggests that while the home care option in the treatment of acutely mentally ill clients may be more expensive, people far prefer it and feel that it is less restrictive and reduces the potential of stigma attached to being admitted to a psychiatric hospital. Existing studies found that clients receiving home care treatment were more likely to remain in contact with services than clients receiving standard community care.

3.1 Setting up of the Home Care Service

The management team comprising of the Clinical Director, Director of Nursing and Area Mental Health Manager initiated the project within budgetary constraints by closing beds in Elm Mount acute unit and deploying staff to Réimse Home Care. They identified a base at Vergemount Day Centre, from which the team would work and it was agreed this would be the focal point for referrals. A steering committee comprising of the Management Team members, Clinical Nurse Manager 3 and an identified Assistant Director of Nursing was formed. The focus of the group was to visit services within the Health Service Executive, where Home Care teams were already in operation in order to gain insights into what works best.

Subsequent to this, the Steering Committee goal was to draw up a model of integrated care that would meet the home care needs of our clients. The Nurse Practice Development Coordinator for the service (MCB) was invited to join the committee in order to assist in policy development and training needs.

3.2 Goals of the Home Care Project

The goals of the home care service were aligned to the general Principles agreed by the team. The agreed aims were to:

- Provide enhanced assessment & treatment to clients who were living in the designated catchment area for a defined period of time
- Assess new clients to the service only following review by a consultant psychiatrist
- Involve the referral of clients with a major psychiatric illness previously known/attending the service, considered ‘acutely ill’ and who would otherwise require admission or where needs were not being met by existing services

The service philosophy of care states that “patient centered treatment and care will be delivered, with assessment and treatment agreed in consultation with the client, his/her family and/or carers.”

3.3 Referral Process

A referral form was developed together with a protocol for ensuring the completed referral form would be faxed to the Réimse Home Care office, together with an initial risk assessment of the client that would be carried out by the referring agent. All referrals would come from the Mental Health Teams. No referrals would be accepted directly from General Practitioners. It was agreed that there should be a same day response to referrals received before 11 a.m. and a response within 24 hours to all referrals received after 11 a.m. A
joint assessment (by the Registrar and Nurse where possible) would be carried out on the initial meeting using the ICP assessment documentation developed in-house. A treatment plan would then be drawn up based on the initial assessment and completion of Risk Assessment (based on an instrument adapted to meet the needs of the service (Morgan 2000)).

Frequency of client contact by Réimse Home Care may range from several times daily to a minimum of twice weekly. Client progress is discussed at the weekly multidisciplinary team meeting. Decisions are made about whether to continue a client on home care or discharge them back to their own team for follow up by their regular Community Mental Health Nurse. The decision to admit a client to hospital can be made at any time if the Home Care Service is considered no longer appropriate.

3.4 Procedures & Guidelines Developed For The Service

Policies and procedural guidelines were developed and agreed by the Multidisciplinary Management Team. These included the referral criteria, referral process, assessment and treatment process, medication management, Lone Worker Policy, relevant use and management of documentation. Furthermore, client information leaflets were prepared. One information leaflet was devised for all staff in the service while a separate Information leaflet was compiled for clients and/or their carers. It was agreed that following on from the training programme, which the staff would attend prior to commencement of the project, a series of information sessions would be held in order to inform all relevant staff in the wider community of the service. A Powerpoint presentation together with the information leaflets were prepared and later presented by the Assistant Director of Nursing and team members to all staff at different locations over a two-week period.

3.5 Liaison with Multidisciplinary Teams

The importance of communication as a means of ensuring continuity of care was discussed and it was decided that a member of the Réimse Home Care team would attend the mental health team meeting in Elm Mount Unit which is held weekly and attended by all sector multidisciplinary team staff representatives. In order to ensure minimum time lost to the service, it was agreed that a time slot would be allocated to the Réimse Home Care staff representative attending, and he/she would be excused from the meeting following discussion of the home care clients.

3.6 Training Programme

A one-week training programme was organised based on the results of a Training Needs Analysis of all staff assigned to the team. The training programme covered topics from the DETECT Programme, training in the use of Assessment Scales for Positive and Negative Symptoms (SAPS and SANS) tools, and the use of all documentation
including risk assessment and management. Furthermore, an overview of setting up Home Care Treatment Teams, safe working in the community, relapse prevention and family education were included. Other topics included Medication Management, Basic Life Support Training, Management of Violence and Aggression, Team Building and Psychosocial Interventions (Appendix 1). The community Garda assigned to the area, together with a representative from the Superintendent’s Office, attended for a meeting with the team and were informed of the project.

Staff requested that they get some practical experience with an established Home Care Team prior to commencement of the service. The Director of Nursing in Dublin South/West Services (where the first Home Care Service was set up in Ireland) was approached and agreed that staff could accompany the Home Care Teams on visits in that area. All staff attended either Clondalkin Home Care Services or Crumlin Home Care Services where they “shadowed” the staff working in these areas, prior to their commencement of work with Réimse Home Care Service.

3.7 Model of Home Care adopted

The model of home care that was identified as suiting the needs of clients, and this service, was the Assertive Community Treatment (ACT) framework. This is a team-based approach widely used as a means of treating people with mental illness within the community thus reducing the time patients spend in institutions (Stein & Test 1980; Marshall & Lockwood 2000). Team members share responsibility for their clients and it is common for several people to work together with the same client. The aim is to provide treatment at home and prevent admission to acute wards. Unlike the Case Management model, which emphasis professional autonomy and individual responsibility, a major distinctive feature of Assertive Community Treatment teams is this group responsibility for care. The goals of the Home Care Service are encapsulated in the ACT model (Marshall and Lockwood 2000, Joy et al. 2006).

3.8 Team Assigned to the Service

The team consists of six registered nurses and 1 ADON who are employed on a fulltime basis. They have access to the clients’ MDT when required. Leadership and support is provided by a designated consultant psychiatrist who is accessible to the home care team at all times and also attends a weekly team meeting.
It was agreed that an evaluation of the service would be take place after six months in order to determine if the service functions as proposed, and in accordance with policies and guidelines developed prior to its commencement.

4.1 Aims & Objectives

Aims

The overall aim of this study is to carry out a six-month evaluation of Réimse Home Care (assertive community treatment) Service, which was set up to offer home care and treatment to clients suffering from acute mental illness.

Objectives

(i) Develop an audit tool to determine whether the agreed service policies and procedural guidelines were followed and carried out
(ii) Determine client satisfaction with the Home Care Service
(iii) Explore staff perceptions of the service
(iv) Make recommendations for future service development

4.2 Methodology

This section describes the methodology used in this study. The design of the study is presented and issues related to sampling are described. Ethical considerations and the process of data collection and analyses are discussed.

4.2.1 Data Collection Tools

Audit: A Questionnaire

In order to audit the Réimse Home Care documentation, a questionnaire was developed using the Quasar Audit software. The Audit Tool is a library of questions built to reflect the type of survey to be carried out while the survey is carried out using the questions selected from the audit tool (Health International 2005). The possible responses are Yes, No or N/A, with a comment section that allows for an entry of explanation to be added where necessary. This response type allows for an overall compliance rate in percentage terms (Appendix 2). The policy and procedure documents, that were developed for Réimse Home Care, were used to formulate the questions for the survey. The survey was used to assess if the policies and procedural guidelines were adhered to (Appendix 2). These related to:

- the agreed referral process
- assessment process
- primary diagnosis of clients accepted for treatment
- individualized care plans written and reviewed regularly
- the length of stay in Réimse Home Care by clients
- the number of clients who required admission to hospital while receiving care from the Réimse Home Care team

A satisfaction questionnaire, devised for the study, was posted out to each client.
who had received treatment from the Réimse Home Care team, in order to explore clients’ satisfaction level with the services provided (n = 50). An explanatory letter was sent with each questionnaire explaining the reason for the survey, asking for assistance by completing the questionnaire and making people aware that they were under no obligation to complete and return it and ensuring confidentiality (Appendix 3).

A Focus Group Part three of the study involved staff participation in a focus group exploring the major themes identified in the questionnaire. All staff in Réimse Home Care were invited to attend in order to capture staff perceptions of the service. The questions for the focus group interview were drawn up from themes that emerged from the results of the audit of documentation and the results of the patient’s satisfaction survey. An explanatory letter was sent to each staff member together with a letter of consent that they were asked to sign if they agreed to take part in the focus group (Appendix 4).

Focus groups are defined as a ‘qualitative research technique used to collect data about feelings and opinions of a small group of participants about a given problem, experience or service’ (McLafferty 2004). This allows the researcher to validate and expand on quantitative findings using open-ended questions. Preparation for the focus group meetings were drawn up using a recognized guide (Bell 2005) (Appendix 5).

When considering the methodology, the main aim was to create a forum that would facilitate the ‘lived experiences’ of the participants and encourage each individual to express their personal experiences. It was decided that a facilitator (EM), who had no contact with the service, would be invited to carry out the focus group interview. Focus groups assist in exploring sensitive issues. It also provides an opportunity to come together and voice collective concerns. It facilitates discussion in a social situation to engage in reflecting on specific issues (Webb & Kevern 2001).

Information obtained from the audit as well as the completed questionnaires were analysed and a series of open-ended questions compiled which were used in the focus groups. Formal written consent was obtained from each person participating in the focus groups. The format of the group was explained in oral and written form and they were made aware that they could terminate participation at any time (Appendix 4).

4.2.2 Research Procedures
In order to address the study aims and objectives, quantitative and qualitative methods of data collection were implemented. By using triangulation, it is recognized that many research studies can benefit from multiple measures.

According to Barbour (1999), “A combination of qualitative and qualitative measurement strategies can increase the information yield and strengthen the external validity of the results.” Issues such as clients’ input into treatment, information received about
medication, satisfaction with treatment and the treatment process as well as overall satisfaction with this service were explored. Possible responses on a 7-point Likert Scale ranged from 1 “most negative” to 7 “most positive.” A rating of zero on the scale indicates an item that is not relevant to the respondent. A number of questions were reverse scored to minimize response bias.

Additional qualitative information was gathered by inviting respondents to ‘please comment on your experience’ at the end of each question. This allowed the clients to express their views and opinions on each topic. Qualitative data was analyzed using Colaizzi’s Framework for Phenomenological Analyses. This involves ‘reading or listening to the text, writing down any ideas, feelings, or responses that emerge as themes during data collection and supports reductive phenomenology (Colaissi 1978; Sanders 2002).

A patient satisfaction questionnaire, devised by Gerber & Prince (1999), informed the composition of the client survey (Appendix 3). The number of questions was reduced from twenty-one to eighteen and a section added to allow for the collection of demographic information. The removal of irrelevant questions was decided among the team. For example, one section dealt with information about reading one’s own file. This section was not included as access to ones personal file in Ireland requires the client to make application under the Freedom of Information Act to the Health Services Executive.

Advantages of Using Questionnaires (Bell 2005)

- Questionnaires are the quickest, cheapest, most confidential and anonymous method of collecting data from a large amount of people. Participants are asked the same question in the same format.
- Objective information may be collected minimizing subjectivity on the part of the researcher.
- They offer complete anonymity which is important when collecting information without bias.

However, Dillman (2000) describes issues that may impact upon survey design and administration. They provided useful guidance and are:

- Respondent–friendly questionnaire
- Multiple contacts with an additional contact (contact letter, questionn- aire, and information from Réimse Home Care team that a questionnaire would be sent out to participants)
- Return stamped addressed envelope
- Personalisation of correspondence

Staff from Réimse Home Care informed clients that they would get an opportunity of making their views known regarding the service and they would receive a questionnaire in the post. Staff also ensured participants that the questionnaire would be totally anonymous and evaluated by a staff member who was not attached to the team.
Potential problems were minimised by including the total population in the survey and distributing a detailed letter with the questionnaire. This explained the purpose of the study and outlined clearly what was required of the participant. An assurance of confidentiality and anonymity was provided in the letter (Appendix 6).

4.2.3 Validity & Reliability
Validity refers to the degree to which the questions in the questionnaire accurately represent the phenomena being examined (Polit & Hungler 1999). The questionnaire used was validated in a study by Gerber & Prince (1999).

4.2.4 Population & sample
Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Hungler 1999). The overriding consideration in assessing the sample in a qualitative study is its representation. The target population for this study was the total number of clients who received treatment from the Home Care Service in the last six months (n = 50).

4.2.5 Inclusion & Exclusion Criteria
Polit and Hungler (1999) advise that eligibility factors for inclusion in the study are considered. Participants for this study were selected using the following criteria.
1) All participants treated by the Home Care Team in the six months from March to September
2) All participants willing to complete the questionnaire
3) All staff assigned to Réimse were invited to attend the focus group

Ethical Considerations
The study was undertaken in Mental Health Services Dublin South East lead by the Nurse Practice Development Coordinator (MCB). Approval was gained from the Hospital Management/Ethics committee to carry out the study. A copy of the Research proposal was submitted to the committee. This outlined the aim of the study together with the proposed design. Copies of the audit document, the patient’s satisfaction questionnaire, letter of explanation to the clients regarding the questionnaire, and letter of information and request to staff seeking their permission to carry out the Focus Group interview were also submitted. Approval was granted by the committee in writing to carry out the study (Appendix 7).
5. THE FINDINGS

5.1 Audit Results

In relation to the assessment and treatment process, there was evidence of assessment, permission being sought from the clients prior to referral to Réimse Home Care, evidence of the treatment plan being drawn up and an evaluation of that plan in 100% of cases. However, the audit of the documentation highlighted a number of issues.

There was no evidence of Multidisciplinary Team involvement in the initial assessment. There was some evidence that a Registrar did go out to the clients’ homes when requested and that two nurses carried out all initial assessments. The preliminary Risk Assessment was carried out by the referring agent on all occasions and completed as part of the initial assessment by the assessing team. Policies regarding staff risk management and the Lone Worker Policy Guidelines were adhered to in 100% of cases reviewed.

The agreed goals of the Réimse Home Care Service documented prior to the commencement of the service were to:

- Provide enhanced assessment & treatment to clients with a major psychiatric illness who are acutely ill
- Prevent admission
- Provide community treatment/care to meet the needs of clients who’s needs are not being met by existing services

In relation to providing enhanced assessment and treatment to acutely ill clients, the overall compliance rate was 50%. There was evidence of clients being referred on a weekend basis for “support over weekends.” A number of other clients had multiple referrals and some clients were only discharged for a few days when they were re-referred back to Réimse Home Care for support.

In relation to specific plans being put in place, there was 70% compliance. There was evidence of SAPS and SANS assessment being used by staff in the evaluation of a client’s response to treatment and care. There was no evidence of a solution-focused therapy approach to care being used. While there was evidence of issues with medication concordance for some clients, there was no indication of the use of the Self Administration of Medication Programme (SAMP) (Noone 2007 unpublished). This is known to increase the client’s knowledge of the importance of medication concordance and relevant education regarding effects and side-effects of the medication that they are taking.

The “involvement of family in the treatment plan” yielded a 50% compliance rate. This was most likely due to the fact that a large number of clients did not have family who could be engaged in the clients care. Where there was family living with the client, there was evidence of reassurance being given to the family/carer but no specific therapeutic interventions were specified in the care charts. There was evidence of two or more visits per day or one visit and a phone call being carried out by Réimse Home Care staff in the first few days following assessment. This reduced down to two visits per week prior to discharge back to the client’s own treating team.
5.2 Patient Satisfaction Survey Results

5.2.1 Demographic Information
Questionnaires (n = 50) were posted to clients who received treatment and care from Réimse Home Care. This represented the total client population for the six-month period. Nineteen completed questionnaires were returned representing a 38% response rate, with one unopened envelope returned by An Post marked “no longer at this address.” Demographically, the male to female response rate was 47% to 53%, respectively. Of the nine male respondents, six were 31-49 years of age and three were >50 years of age. Six described themselves as single and three were divorced. Six were living alone while one lived with a partner and two were living with a family member. Five were unemployed, two were employed full-time and one was retired. The female respondents numbered ten. Six were aged 31-50 years of age, three were >50 years while one was within the 22-31 years age range. Five were single, four were married and one divorced. Eight females were unemployed, one retired and one responded as “other.”

5.2.2 Quantitative Information
Results are displayed and show the exact response scale to each question. Respondents indicated a high level of satisfaction to all 18 questions asked (see Appendix 7). The questions were divided into different domains with Questions 1-3 aimed at eliciting satisfaction regarding input into clients’ treatment. Questions 4-6 referred to “specific” treatment and questions 7-9 about medication. Questions 10-18 relate to the treatment process and “general” questions about treatment. In general, high levels of satisfaction were indicated across all of the domains covered in the survey. There was greater satisfaction indicated by respondents to questions about information given about different treatments available than with input into their own treatment plan. A significant number (90%) of respondents indicated that information given was “good” or “very good”. Half of respondents (50%) indicated they felt that their influence over their own treatment was “great” or “very great.”

In relation to conversations with their worker, 99% of respondents felt that the staff had “always” enough time for them during conversations while 86% felt that their worker understood their problem “very well” and found their conversations with the worker “very helpful.”

In response to questions regarding medication, a majority (65%) indicated they felt they were given “good” or “very good” information about potential side effects, although 30% indicated they were given “no information” or “very poor information.” A high proportion of respondents (70%) were satisfied with the amount of medication they were given while two respondents (10%) indicated that the question was “not applicable” to them.

In relation to questions regarding the treatment process, the satisfaction rating was lowest on this domain. In response to question 10, 50% felt the planning of their treatment was “very well done” while 25% indicated they felt it was “fairly well done.” The lowest satisfaction rating was indicated in response to the question regarding the cooperation of the staff who worked
together in treating clients (Q11). 60% choose the neutral option of “neither good nor poor,” while 35% indicated they felt it was “very good” or “good.” Two respondents did not rate this question. There were a number of comments recorded in this section indicating that clients were unaware of what staff members, other than the nurse who visited them, were involved in their treatment.

Responding to general questions about their treatment, 75% of respondents felt that they could “always trust” or “almost always trust” the staff. 95% of respondents indicated they felt the treatment they received from staff was “very good” or “good.” The same percentage was also “very satisfied” or “satisfied” with the extent of the help they received and would recommend the service to a friend.

5.2.3 Qualitative Data from satisfaction questionnaire

A number of themes emerged in relation to what clients valued about their experience of Réimse Home Care. The main themes were:

1) Relationship with Staff
2) Treatment Planning and Team Involvement in Client Care
3) Feeling Understood
4) Valuing the Service
5) Medication Issues

In this section, each of the emerging themes will be presented and discussed in turn.

Theme 1: Relationship with Staff

The one-to-one relationship between the worker and client is a fundamental aspect of care. Burns and Firn (2002) found that clients felt the relationship with staff as “more authentic.” The importance of the relationship with Réimse Home Care staff was evident in comments made by a number of respondents:

“I really felt that home care had time for me, they didn’t rush me and were there to listen.”

“All the staff are very good but I liked being in my own home most.”

“This is a great service. They came when they said they would and - I wasn’t here they rang that evening to make sure I was all right”...

“’I have not been admitted as much to hospital’.

“The team helped by visiting and talking me through my illness.”

“They have made me feel very secure at home, comfortable, at ease in myself, spontaneous feeling good about myself.”

“The people who called here were sincere and honest, well mannered, sometimes I felt they can’t help me because I’m just stranded above and there is nothing these people can do about it.”

The time staff spent with clients was an important aspect of the service from the client’s perspective. A number of respondents commented on this:

“My case worker spent plenty of time with me.”
"I found my worker spent enough time with me and was very generous with her time."

"My nurse would sit me down and focus on me and didn’t rush."

"I got great support from my social worker when I came out of hospital."

Theme 2: Treatment Planning & Team Involvement in Client Care

The Vision for Change policy document proposes multidisciplinary home care teams who will provide treatment and care in the community for clients with mental illness (Department for Health and Children 2006). In the present study, the respondents did not view the Home Care team as part of the overall service provided to them but as a separate entity. This is evident in the response to questions 10, which elicited opinions on the teams planning of clients’ treatment. Ten out of twenty respondents (50%) chose the most favorable answer, while one respondent chose the neutral option and two indicated that they felt treatment was poorly planned. Seven respondents indicated they felt the planning of their treatment was “well” or “fairly well” done. Clients elaborated:

"The only plan was the visits... Supposed to go for bio-feedback but it never happened."

"I know my own treatment."

"Too much medication and nothing else was offered to me."

Question 11 elicited information on how clients felt about the cooperation of staff (psychiatrists, social workers, nurses) that treated them. Twelve respondents chose the neutral option of “neither good nor poor.” Comments indicating that clients were unaware of team involvement in their treatment and care while with Réime were given:

"I am not sure who planned it other than the nurse that was with me."

"I didn’t see a team just the nurse that came here."

"No one else was involved I think. I had some say and so did my ma but that was it I mean there was no one else that I know, I go to Baggot Street, but it’s a different chart and everything, I think."

Theme 3: Feeling Understood

Joy et al. (2006) found that Home Care is more satisfactory from the client’s perspective. Family and carers also considered it a better form of treatment to hospital care. The clients in this study valued being treated in their own home by competent staff who they felt understood them:

"My worker understands me and listens it’s good to have a good listener. I had her total attention at home."

"It’s impossible to understand unless you experience it but they were more supportive and knowledgeable than the ordinary person."

Theme 4: Valuing the Service

One of the advantages of Home Care Treatment is that it may reduce the stigma attached to being admitted to a psychiatric hospital. Commander et al (2005) and Gibbons et al (2006) suggest that Home Care reduces disadvantages associated with admission to a psychiatric ward that may include emotional trauma, stigma and a
“revolving door” process. Clients indicated that they valued the service and indicated that they felt it reduced the stigma attached to their illness:

“I received excellent care. I think it a very good service I never felt alone with my problems.”

“I think it’s a good service especially for mental health to be more community based and everyone is aware of the cut backs in health care I think there should be more services like this.”

“It means you can be treated in your own home without the stigma attached to going into a mental ward.”

“I just hope that this service can continue financially & regarding manpower as I know its essential care.”

**Theme 5: Medication Issues**

Interestingly, fourteen out of twenty respondents (70%) felt they were given about the right amount of medication while one respondent felt they were given too much. Thirteen respondents (65%) said that the side effects of the medication were troublesome and seven respondents (35%) felt it was not especially troublesome or virtually unnoticeable. Comments varied:

“I find it frustrating that I am always nearly overmedicated making me feel very drowsy during the daytime.”

“It is tempting sometimes not to take the medication.”

“I’m used of them now.”

“I was not given medication by the home team but by the hospital where

I was admitted as an involuntary patient, it was the most damaging experience of my life.”

Fell & Sweeney (2007) suggests that one of the reasons for repeat hospital admissions is non-compliance with medication. One reason for non-compliance may be a lack of sufficient information regarding the potential benefits or troublesome side effects of the medication clients receive. Only 65% of respondents indicated that the information they received regarding effects and side effects of medication was “very good” or “good.” 15% indicated that no information was given to them. 20% indicated they felt the information given to them was poor. Furthermore, the audit results showed that there was no evidence of education being provided to clients on medication. Comments made in this section revealed dissatisfaction with the information given about the effects and side effects of medication:

“I was pretty much left to discover nasty side effects, when I reported them to the doctor he said they were from the medications. It seems like the psychiatric system is under the sole influence of the pharmaceutical companies. They only mask the symptoms.”

“I’m a long-term patient and read all the leaflets that come with the meds.”

Three respondents indicated that they had received no information about medications whatsoever.
5.3 Analysis of Focus Group

The focus group was held in November 2009 and the analysis of results utilised Colliazis’s framework, as outlined previously. Focus groups interviews are defined as a qualitative research technique used to collect data about feelings and opinions of a small group of participants about a given problem, experience or service (Bell 2007). This allows the researcher to validate and expand on quantitative findings using open-ended questions (Morse and Field 2002).

Seven participants were all nurses assigned to the home care service and took part in the focus group discussion which was facilitated by an external facilitator (EM). A structured approach to the focus group interview was adopted with questions pre-prepared. The questions were designed as open-ended questions. This allowed for the interviewer to ask more in-depth questions in order to capture the thoughts and feelings of the group.

Prior to commencement, full information was given verbally about the purpose of the focus group and guarantees given about anonymity and confidentiality. All participants had received written information and had signed consent prior to setting up the interview. With the participant’s permission, the interview was recorded using audio equipment. The topics explored in the focus group were devised from the main themes that emerged from the results of the audit and the questionnaire. The focus group interview was transcribed verbatim and subjected to a thematic analysis.

1) Team Function & Roles

Staff described their role as working with the patient in their own home providing care and support to both the client and their family or carer. All of the staff felt that the service was important and there was an obvious commitment and enthusiasm from staff members towards the project. This was evident from their willingness to come to work on their time off to attend meetings and In-service Training. All staff felt that their job was more challenging in Home Care than when working in the hospital environment. However, they also felt they had more professional autonomy and enjoyed the responsibility their new role gave them.

Peer support was the main source of support from within the team. The team felt that the fact that two staff always carried out the first assessment was beneficial. They felt less isolated and care decisions were made by the team. Organisational, management support is provided by the Clinical Director and Director of Nursing. Staff development occurs through Team Days and all staff attend whether they are on duty or not.

Group participants discussed the advantages of providing care and treatment to clients in their own home. They felt that it afforded an opportunity to see the family dynamics and living circumstances of the client and this allowed practitioners to understand the client’s holistic needs better.

Identified “interventions” involve carrying out an assessment of clients needs and formulating the care plan from this. Education of the client about their illness, health education and the use of the SAPS and SANS in order to
track a client’s progress were identified as specific interventions used.
Fifty one clients were treated by the Home Care Service in the first six months, with 85 referrals accepted. The majority of referrals to the team came from Outpatient Clinics. Other referral sources were the Psychiatry Liaison Registrar at St. Vincent’s Hospital and Community Mental Health Nurses. The majority of clients referred suffer from “schizoaffective disorder” (75%) followed by bipolar disorder (15%) and “other disorders” (10%). 17% of clients were admitted to Elm Mount Approved Unit while being treated by the Home Care Team.

2) Challenges Identified
Staff felt that lack of a Day Hospital where they could refer clients to was a major problem for the team. While there are two Day Centres in the service, they felt the majority of clients they serve “need a higher level of input and supervision than can be afforded by these centres.” One nurse elaborated:

“We have made a proposal to local hospital management for the opening of an Acute Day Hospital, which allows for quick assessment and access. This would work in tandem with the Home Care Team. We feel that such a facility would be of great benefit and would be a further expansion of our community service. It would also reduce the number of home visits as our clients could be seen in the Day Hospital.”

Lack of access to medical backup when needed was also identified. On some occasions participants felt this resulted in clients being “admitted to the acute unit for stabilization.” This caused “frustration” for staff as they felt the client could perhaps be better managed in the community, had there “been the required resources in the team to meet that client’s needs.”

Staff expressed concern about the criteria for “acutely unwell patients” or “patients in the acute phase of their illness” not being referred to the Team. The nurses felt that the criteria agreed prior to setting up the project is not being adhered to but they are accepting “most if not all of the referrals.” The main referral criteria agreed was that the client referred should be “acutely unwell” or “in an acute phase of their illness,” but that has generally not been so. One nurse stated:

“Our records have shown that our main referrals have come from those with “Non Acute” symptoms, but whose symptoms and treatment need more input as can be afforded by our Community Mental Health Nurses. Most of the referrals we see are severe and enduring mental illness.”

They also expressed views that sometimes they have difficulty discharging the clients back to their own team. One nurse explained:

“Sometimes discharging clients back to their own team has proved difficult despite the fact that each client has a treatment and discharge plan. There’s reluctance on the part of some teams to accept the client back when home care had nothing else to offer the client.”

The team felt that a review of the ‘target population’ criteria for Réimse Home Care was necessary. One nurse suggested:
“We could look closely at the needs of our clients with severe and enduring mental illness and to setting up another Home Care Team for these clients.”

All the nurses agreed that there tends to be a high proportion of clients re-referred at weekends and bank holidays. Figures show that 11% of all referrals were made in order to provide support to clients over weekends. A nurse explained:

“The treatment of these clients would then be transferred back to the relevant team on the Monday morning (or Tuesday morning after a bank holiday weekend), and a report of their weekend progress passed on.”

The lack of a multidisciplinary team approach to the current service was identified as problematic. There is evidence of medical staff carrying out a joint assessment when requested on a small number of occasions and Social Worker involvement on few occasions. Several participants commented:

“The clients continue to attend outpatient clinics while under care of Réimse Home Care.”

“It’s a problem that we have and it’s associated with the high level of admissions.”

“I don’t know whether – in theory it’s an MDT in practice it’s not, we have had need for medical assessment and it hasn’t happened.”

“We want to keep clients home but we need the backup and support when it’s required, not when it can be given.”

Limitations of the Study

There are inherent limitations associated with undertaking any research and this also applies to this study. However, there remained limitations in relation to design and ability to generalise the findings due to the small size of the study.

A shortened version of the Patient’s Satisfaction Survey was used, but due to lack of similar client profile, a pilot of the shortened version was not carried out. The decision not to include the clients’ families or caregivers in the study was made at the outset.

Lack of resources and suitable qualified staff to carry out focus groups was the main consideration. However, the study provides useful evaluation data of a new Home Care Service in one area of the Mental Health Services in Dublin South East and captures the views and opinions of both staff and clients of the service.
Réimse Home Care Service was developed following the reconfiguration of the Dublin South East Mental Health Services. The service is provided by a unit-disciplinary team under the direction and support of a designated consultant psychiatrist. This differs from existing models of Home Care Services in operation (such as Dublin South West), where multidisciplinary teams are assigned on a full-time basis. It is important to acknowledge at the outset that the current Réimse Home Care Service is not operating as an Assertive Community Treatment Service, as was proposed in section 3.7 of this study.

The current service aims to provide a seven-day week, twelve-hour day service. Fifty-one clients (one deceased prior to commencement of study) attended the service and there were eighty-five referrals. Many of the referrals (41%) were re-referrals; all of which were accepted for treatment. A proportion of the clients accepted for treatment (17%) were eventually admitted to Elm Mount Acute Unit while under the care of Réimse. This figure may be seen as significant when compared to reported admission rates for similar services, both nationally and internationally, which ranges around 12-20%. North Kildare Services reported that 4% of their clients required admission while attending Home Care (Gibbons et al 2006). The relatively high rate of admission in this service may be due in part to the lack of an MDT approach to treatment and care.

The admission rate to Elm Mount Acute Unit decreased in 2009 compared to admission figures for 2008. While it is not possible to assert that this decrease in inpatient admissions is due to the commencement of the Réimse Home Care Service, it may have had some influence. There was no significant difference in length of stay for patients admitted to Elm Mount during this period when compared with the same period in 2008.

Discussion
Positive Aspects of the Introduction of Réimse Home Care – There was overall satisfaction indicated by clients who attended the service as evidenced by the satisfaction survey results. Indeed, a significant proportion (95%) said they would recommend the service to a friend.

The standard of care seems to be equal to that provided in the inpatient units. As evidenced by the qualitative information obtained from the Patient Satisfaction Survey, the results suggest that clients valued the service and viewed it as an essential service. Some respondents preferred this service to inpatient care because they felt it reduces the stigma associated with being admitted to an inpatient facility. It is now government policy to involve the “service user in all aspects of service delivery.” Therefore, the importance of eliciting the views and opinions of clients and taking into consideration client preferences is fundamental to the development of modern and responsive holistic approaches to treatment and care.
Focus group discussion demonstrates that staff working in Réimse find it both rewarding and challenging and enjoy the professional autonomy their new role offers.

Challenges Identified
Lack of Interdisciplinary/Multidisciplinary Approach to Treatment and Care – The absence of a multidisciplinary approach to care (the mainstay of Assertive Community Care) is evident. Clients indicated from their comments that they saw Réimse as a separate entity. A large number of clients indicated they did not know who, other than the nurse that came to their home, was involved in their care.

Audit of the charts demonstrated that joint initial assessments were carried out by two nurses in majority of cases with little or no input from other disciplines in the assessment and planning of care. A core service team who can provide the bulk of the clients’ holistic needs should form the basis of a Home Care service.

The Client Group Being Referred
While the stated aim of the home care service was to provide treatment and care to clients in an acute phase of their illness, the majority of clients referred presented with “non-acute” symptoms and “suffering from chronic and enduring mental illness.”

“The Home Care staff in the focus group interview felt that there was a need to review the services provided to this client group. 41% of clients accepted for home care were re-referrals to the service. The reason for this is not clear from this study but it may be due to the fact that the majority of clients referred for treatment were clients with chronic and enduring illness who, due to their symptoms, require greater support than can be provided by existing community services. It could be suggested that Réimse provided that service and prevented readmission to the acute unit for these clients. A further study aimed at assessing the needs of this client group would be beneficial.

Lack of Day Hospital Facilities
The need for a day hospital to augment the work of Réimse was also identified. Challenges were evident around discharging clients back to their own teams when deemed appropriate by Réimse Home Care staff. Good practice would suggest that a protocol should be drawn up and agreed by all relevant staff to ensure the smooth transfer of clients between the services.

Staff Development Needs
Within the Home Care model, there is scope for staff to expand their role in relation to psychosocial approaches including education and support of clients, their relatives/carers. The results of this study are challenging in this respect, as evidenced by both quantitative and qualitative data collected. This may be due in part to the fact that the majority of staff assigned to the project were working in hospital setting previously.
While some “up-skilling” was provided for staff prior to the commencement of the service, it is important to ensure that further development of staff is provided and systematically evaluated. The importance of providing “high quality interdisciplinary teaching programmes such as Thorn Courses” for the professional development of the staff is necessary and should be considered (Burns & Firn 2002: 253).
REFERENCES


# APPENDIX 1 – TIME TABLE ORIENTATION TRAINING

## REIMSE HOME CARE TEAM ORIENTATION TRAINING – 9TH FEBRUARY 2009 TO 13TH FEBRUARY 2009

<table>
<thead>
<tr>
<th>TIME</th>
<th>MON, 9th FEB 09</th>
<th>TUE, 10th FEB 09</th>
<th>WED, 11th FEB 09</th>
<th>THU, 12th FEB 09</th>
<th>FRI, 13th FEB 09</th>
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</thead>
<tbody>
<tr>
<td>08:00 – 08:15</td>
<td>Opening/Introduction Ms. Kay Beggan (Director of Nursing)</td>
<td>Cognitive Behaviour Therapy Ms. Fionnula MacLiam (Clinical Nurse Specialist)</td>
<td>Team Building/Planning Mr. Eddie Keating (Sharps Management)</td>
<td>Therapeutic Management of Violence &amp; Aggression Mr. David Timmons (Central Mental Hospital)</td>
<td>Psychosocial Interventions &amp; Family Education Dr. Ed McCann (Trinity College)</td>
</tr>
<tr>
<td>08:15 – 10:00</td>
<td>MHA 2001-2008 &amp; Assisted Admission Procedure Dr. Freeda O’Connell (Clinical Director)</td>
<td>08:30 a.m. – 09:40 a.m.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00 – 10:30</td>
<td>COFFEE BREAK</td>
<td>COFFEE BREAK</td>
<td>COFFEE BREAK</td>
<td>COFFEE BREAK</td>
<td>COFFEE BREAK</td>
</tr>
<tr>
<td>10:30 – 11:00</td>
<td>MHA 2001-2008 &amp; Assisted Admission Procedure Dr. Freeda O’Connell (Clinical Director)</td>
<td>Medication Management Making The Right Choice Tool Kit (Irish Psychiatry Approved) Ms. Maureen Purcell (Janssen Cilag)</td>
<td>Team Building/Planning Ms. Nessa Lynch (Performance Development)</td>
<td>Therapeutic Management of Violence &amp; Aggression Mr. David Timmons (Central Mental Hospital)</td>
<td>Psychosocial Interventions &amp; Family Education Dr. Ed McCann (Trinity College)</td>
</tr>
<tr>
<td>11:00 – 13:30</td>
<td>DETECT &amp; The Use of SAPS and SANS Dr. Anwar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:30 – 13:30</td>
<td>LUNCH BREAK</td>
<td>LUNCH BREAK</td>
<td>LUNCH BREAK (1 p.m. – 2 p.m.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:30 – 14:00</td>
<td>DETECT &amp; The Use of SAPS and SANS Dr. Anwar</td>
<td>Elder Abuse Ms. Sarah March (Elder Abuse Officer)</td>
<td>Team Building/Planning Ms. Nessa Lynch (Performance Development)</td>
<td>Therapeutic Management of Violence &amp; Aggression Mr. David Timmons (Central Mental Hospital)</td>
<td>Psychosocial Interventions &amp; Family Education Dr. Ed McCann (Trinity College)</td>
</tr>
<tr>
<td>14:00 – 16:00</td>
<td>Overview of Setting Up Home Care Treatment Team, Safe Working In Community, Relapse Prevention &amp; Family Education Mr. Peter Hughes (Clinical Nurse Manager III) Clondalkin/Crumlin Home Care Teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2
AUDIT TOOL: EVALUATION OF RÉIMSE HOME CARE SERVICE

Goal of Réimse Home Care Service

1

Sources: Check patients Notes, Ask Home Care Team
Authors: Madge Conboy Browne, Finola Steemers
Themes: Compliance with Goals of ACT
Weighting: 3

Does the Réimse Home Care Team provide assessment, treatment to clients who are acutely ill at home?

Response type: Yes or No

3

Sources: Check patients notes, assessment /treatment plan section
Themes: Goal of ACT
Weighting: 3

Is there evidence that the treatment meets the needs of the client?

Advice to Auditor: If client is willing to engage with team following the assessment process this may be considered as a sign that the clients needs are met.

Check if there is anything on assessment that has not been followed through, e.g., other services involvement).

Response type: Compliance Rate

Sources: Check patients Notes
Weighting 3

Is there evidence of family involvement in treatment plan?

Response type: Yes or No
What The Service Offers

5

Sources: Information Leaflets, ADON/DON, Ask Home Care Team
Themes: Goal Of ACT
Weighting: 3

Does the service provide a 12-hour / 7-day a week service?

Response type: Yes or No

6

Sources: Check policies, Ask Home care team, Check Referral Forms
Weighting: 3

Is there evidence that the referral criteria as outlined in Policy document is been adhered to?

Advice to Auditor: Client resides in the defined area are required to need more intensive treatment than can be provided by CMHN aged between 18 65 years.

Response type: Yes or No

7

Sources: Consultant responsible for the care & treatment, Ask Home care team
Themes: Goal Of ACT
Weighting: 3

Is there a multidisciplinary team approach to client treatment/care?

Response type: Compliance Rate
8

Sources: Check Patients Notes, Check Referral Forms
Weighting: 3

If a referral is received at 11a.m., does the team respond that day?
Response type: Yes or No

9

Sources: Check Patients Notes, Check Referral Forms
Weighting: 3

When a client is referred after 11 a.m., does the team respond within 24 hours?
Response type: Yes or No

10

Sources: Check Patients Notes
Weighting: 3

What were the No. of contacts, visits and phone calls made to the client daily?
Response type: No of Visits

11

Sources: Check patients Notes
Themes: MDT Involvement
Weighting: 3

Was there evidence of any other discipline other than a Registered Nurse involved in the client's care?
Response type: Yes or No
12

Sources: Check Patients Notes
Themes: MDT Involvement
Weighting: 3

If Yes, specify discipline (e.g., PSW, Registrar, OT)

Advice to Auditor: Please specify where the interaction took place in OPD, A/E Elm Mount or in the client’s home.

Response type: Elaborate on response

13

Sources: Check Patients Notes
Themes: Check Patients notes
Weighting: 3

What was the total number of visits carried out to the client?

Response type: No of Visits

14

Sources: Check Patients Notes
Themes: Competence with Lone Worker Policy
Weighting: 3

Was there evidence that a client was admitted to Hospital while being treated by the Home Care Team?

Response type: Yes or No
Assessment/Treatment Process

15
Sources: Assessment /Treatment plan section
Themes: Competence with Lone Worker Policy
Weighting: 3

Is there evidence that an assessment of the clients holistic needs were carried out?
Response type: Yes or No

16
Sources: Check Referral Forms
Themes: Referral/Treatment
Weighting: 3

Is there evidence that the client's permission was sought prior to referral to Home Care Team?
Response type: Yes or No

17
Sources: Check Referral Forms
Themes: Referral/Treatment
Weighting: 3

Is there evidence that a treatment plan was devised based on the assessment results?
Response type: Yes
Is there evidence of MDT involvement in the treatment plan?

Advice to auditor: Any referral to PSW, OT any other discipline Check Notes for this information.

Response type: Compliance Rate

Is there evidence of evaluation at least weekly of the treatment plan?

Advice to auditor: Record in Notes following weekly meeting.

Response type: Yes or No

Is there evidence that a risk assessment was carried out and sent to Home Care Team as part of referral process?

Response type: Yes or No
22

Sources: Check patients Notes, Any Other Documentation
Weighting: 3

Is there evidence that the team leader made phone contact with the client to arrange time/place for first meeting?

Advice to auditor: Check the records book kept in the Office.

Response type: Yes or No

23

Sources: Check patients Notes, Ask Home care team
Themes: Check patients notes, Compliance with Goals of ACT
Weighting: 3

Is there evidence that following assessment the management of immediate needs were identified and undertaken in collaboration with family as well as the client where possible and desired by client?

Response type: Yes or No

24

Sources: Check patients Notes
Weighting: 3

Is there a record of length of each visit documented in file for each visit?

Response type: Yes or No
Has there evidence of a communication brief been given to team manager following each visit?

Advice to auditor: This may be recorded in a communication book/diary.

Response type: Yes or No

---

### Lone Worker Policy

Is the Home Care Policy and Lone Worker Policy available in the Office easily accessible for reference?

Response type: Yes or No

---

Is there evidence that Part 1 & 2 of risk assessment as part of referral process by the referral?

Response type: Yes or No
29

**Sources:**  Ask Home Care Team, Check Risk Assessment Documents
**Weighting:**  3

Is there evidence that when a risk is identified a process id put in place to protect staff, e.g., two staff carry out visit

Advice to auditor: Need to discuss this with Team members.

Response type: Yes or No

30

**Sources:**  Check Patients Notes, Ask Home Care Team
**Weighting:**  3

Is there evidence that on first assessment of client in his/her home two staff carry out the assessment?

Response type: Yes or No

31

**Sources:**  Any other documentation
**Themes:**  Check any other documentation
**Weighting:**  3

Is there evidence that each team member the "Staff location form?"

Response type: Yes or No
32

Sources: Any other documentation, Ask Home care team
Themes: Competence with Lone Worker Policy
Weighting: 3

Is there evidence that the approximate length of visit, with an agreed time for reporting back on location form?

Response type: Yes or No

33

Sources: Any other documentation, Ask Home care team
Themes: Competence with Lone Worker Policy
Weighting: 3

Is there evidence of the team members’ car details, e.g., Registration, Model of car kept in office?

Response type: Yes or No

34

Sources: Any other documentation, Staff location Form
Weighting: 3

Is there evidence that the number of mobile phone that each member is carrying on duty each day is recorded?

Response type: Yes or No
APPENDIX 3
ASSERTIVE COMMUNITY TREATMENT
CONSUMER SURVEY ON SATISFACTION WITH SERVICES

Instructions:

This questionnaire contains a number of questions about the services you have received from the Réimse Home Care team. Each question should be answered by circling the number beside the appropriate answer. In some of the questions, you can circle the answer marked "O" which means that the question does not apply to you.

At the end of each question, you will find space for your personal comments. Please use this opportunity to comment on your experience with the services you received.

Part 1 – Demographic Details

1. Sex of person completing this questionnaire.
   □ Male          □ Female

2. Age of person completing this questionnaire.
   □ 18-21         □ 22-30         □ 31-50         □ 50 - over

3. Marital status of person completing this questionnaire.
   □ Single        □ Married        □ Widow/Widower
   □ Divorced/Separated □ Other

4. Employment Status
   □ Employed Full-Time □ Employed Part-Time □ Retired
   □ Unemployed        □ Other

5. What are your current living arrangements in terms of the people you are living with?
   □ Living Alone
   □ Living with a spouse/partner
   □ Living with a spouse/partner/children □ Other
Part 2 – Questions About Information & Your Input Into Treatment

1. Were you given enough information about the different treatments which were available in your case?

The information about the different treatments was:

7) Very Good
6) Good
5) Fairly Good
4) Neither Good nor Bad
3) Fairly Bad
2) Bad
1) Very Bad

Please comment on your experience ________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2. Do you think that your opinion was given enough attention in deciding your treatment?

The attention given to my opinion was:

1) Very Small
2) Small
3) Fairly Small
4) Neither Small nor Great
5) Fairly Great
6) Great
7) Very Great

Please comment on your experience ________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
3. My influence over the treatment plan was:

7) Very Great
6) Great
5) Fairly Great
4) Neither Great nor Small
3) Fairly Small
2) Small
1) Very Small

Please comment on your experience __________________________________________
__________________________________________
__________________________________________
__________________________________________

Questions About Treatment

4. Did you feel that your worker had enough time for you during the conversations that you had?

In conversations with my worker, my worker had enough time:

7) Always
6) Nearly Always
5) Often
4) Sometimes
3) Now and Again
2)Nearly Never
1) Never

Please comment on your experience __________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________
5. Did you feel that your worker understood your problems?

My worker understood me:

7) Very Well
6) Well
5) Fairly Well
4) Neither Well nor Poorly
3) Fairly Poorly
2) Poorly
1) Very Poorly

Please comment on your experience __________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. Do you think that conversations with your worker helped you?

The conversations with my worker were:

7) Very Helpful
6) Helpful
5) Fairly Helpful
4) Neither Helpful nor Unhelpful
3) Fairly Unhelpful
2) Unhelpful
1) Very Unhelpful

Please comment on your experience __________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
7. Do you think you were given too much or too little medication?

0) I didn’t get any medication

I was given:

1) Far too much medication
2) Too much medication
3) Somewhat too much medication
4) About the right amount of medication
5) Somewhat too little medication
6) Too little medication
7) Far too little medication

Please comment on your experience __________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8. How have you been informed about the effects and side effects of the medications that you are treated with?

0) I am not treated with medications

The information given to me about my medication is:

1) No information was given
2) Very poor
3) Poor
4) Fairly poor
5) Neither good nor bad
6) Fairly good
7) Good
8) Very good

Please comment on your experience __________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
9. What did you think about the medication side-effects?

0) I wasn’t given any medication

The side effects of the medication were:

1) Very troublesome for me
2) Troublesome
3) Fairly troublesome
4) Noticeable
5) Not especially troublesome
6) Hardly troublesome at all
7) Virtually unnoticeable

Please comment on your experience ________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Questions About The Treatment Process

10. How do you feel about the team’s planning of your treatment?

The planning of my treatment was done:

7) Very well
6) Well
5) Fairly well
4) Neither well nor poorly
3) Fairly poorly
2) Poorly
1) Very poorly

Please comment on your experience ________________________________

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
11. How do you feel about the staff (e.g., the psychiatrists, social workers, nurses) who worked together in treating you?

The cooperation of the staff was:

1) Very poor
2) Poor
3) Fairly poor
4) Neither good nor poor
5) Fairly good
6) Good
7) Very good

Please comment on your experience ________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

12. How do you feel about the demands that were placed on you during your treatment?

The demands that were put on me were:

1) Far too high
2) Too high
3) Somewhat too high
4) About right
5) A little too low
6) Too low
7) Far too low

Please comment on your experience ________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________
General Questions About Your Treatment

13. Did you feel that you could trust the staff on the Réimse Home Care Team?

I felt I could trust the staff:

1) Never
2) Almost never
3) Now and again
4) Sometimes
5) Often
6) Almost always
7) Always

Please comment on your experience ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

14. In total how would you rate the help you received from the Réimse Home Care team?

The help I received from the team was:

7) Very good
6) Good
5) Fairly good
4) Neither good nor bad
3) Fairly bad
2) Bad
1) Very bad

Please comment on your experience ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
15. Were you offered the kind of help that you wanted?

I was offered the kind of help that I wanted:

1) to a very small degree
2) to a small degree
3) to a fairly small degree
4) to neither a large nor small degree
5) to a fairly large extent
6) to a large extent
7) to a very large extent

Please comment on your experience ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

16. To what extent has the Réimse Home Care team met your needs?

1) To a very small degree
2) To a small degree
3) To a fairly small degree
4) To neither a large nor small degree
5) To a fairly large extent
6) To a large extent
7) To a very large extent

Please comment on your experience ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
17. How satisfied are you with the extent of the help you were given?

I am:

1) Very dissatisfied
2) Dissatisfied
3) Fairly dissatisfied
4) Neither satisfied or dissatisfied
5) Fairly satisfied
6) Satisfied
7) Very satisfied

Please comment on your experience ____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

18. If a friend were in need of similar help, would you recommend the Réimse Home Care team to him or her?

1) Definitely not
2) Probably not
3) Possibly not
4) Undecided
5) Possibly would
6) Probably would
7) Definitely would

Any further comments you wish to add __________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Thank You for taking the time to complete this Questionnaire
APPENDIX 4
FOCUS GROUP INVITATION LETTER TO STAFF

6th October 2009

RE: Focus Group Attendance as Part of Evaluation of Réimse Home Care

Dear ______________________,

I would like to invite you to participate in a focus group as part of the evaluation of Réimse Home Care. A focus group is a “qualitative research technique used to collect data about feelings and opinions of a small group of participants about a given problem, experience or service” (Bell 2007). This allows the researcher to validate and expand on quantitative findings using open-ended questions. I have attached a Consent form and a copy of what the focus group intends to explore for your attention.

Your experience of working in Réimse is invaluable to the evaluation of the project and necessary in order to determine if the project is meeting its stated goals when set up as well as changes, if any, that may be required.

Dr. Eddie McCann, Trinity College, has agreed to carry out the Focus Groups in the interest of maintaining a non-biased approach to the study. He is available each Friday and I would be delighted if you, as a group, would discuss and agree a time that would suit (23rd October, 30th October, 6th November, 13th November or 20th November).

I am also attaching a consent form and would be delighted if you could complete and return to me to indicate your willingness to attend.

Please do not hesitate to contact me if you have any queries regarding this and I am available to meet with you in order to discuss any concerns you may have.

Thanking you for your cooperation.

Kind Regards,

____________________________________
Madge Conboy-Browne
Nurse Practice Development Coordinator
Study Title: Evaluation of Réimse Home Care Six-months on.

Investigator: Dr Eddie McCann, School of Nursing, Trinity College, Dublin.

The aim of this focus group is to explore the experiences of staff in relation to the development, commencement and working in Réimse Home Care.

All information discussed in the focus groups is totally confidential unless you disclose something of an unethical nature, in which case the facilitator is obliged to bring such a matter to the relevant authorities.

Please respect the confidential nature if each others discussions and do not disclose outside this forum.

The tape recording will be securely stored and all information collected on tape will be destroyed as soon as it is analyzed.

This study comprised of three parts:

1) Examination of documentation held by Réimse in order to determine if the project was implemented as outlined in Policy documents.

2) Focus group interviews exploring the individual experiences of staff in relation to the development, commencement and working in Réimse Home Care.

3) A survey questionnaire which was circulated to all the clients who have received care from Réimse Home Care.

Themes form the raw data collected will be used to devise open-ended questions for the focus groups.

You are not obliged to partake in the focus group and you may withdraw your consent at any time.

Declaration

I have read and understand this information given to me. I have had an opportunity to ask questions and all questions have being answered for me.

I understand that I can terminate my involvement in the focus group at any time without explanation

Participant’s Name/Signature: ________________________________

Date: ________________________________
Appendix 5

12. Select who to interview.

Interviews take time. Try to select a representative sample. Decide what to do if selected people are not willing or able to give an interview. Be realistic about the number of interviews that can be conducted in the time available.

13. Try to fix a time and place where you will not be disturbed.

A letter from your supervisor, head or principal, explaining the purpose of the research may be helpful. Say what will happen to the information provided by the interviewee. Clarify the meaning of anonymity in the context of the study.

14. Make sure official channels have been cleared, and let interviewees see any protocol documents beforehand.

Do your utmost not to exceed the time limit.

15. Introduce yourself and give interviewees the opportunity to ask for any necessary clarification. You will, of course, have already sent a letter and a statement outlining the purpose of the research.

But don’t promise to check with respondents after the interview if this is likely to prove difficult.

16. Agree with the interviewee how long the interview will last.

Remember that it takes a long time to transcribe a tape-recorded interview, if this is what you intend to do. Write up as you go along. Don’t wait until all interviews are completed.

17. Try to check the accuracy of your notes with interviewees, particularly if some items might be quoted in the report.

Make no promises that cannot be fulfilled. Respect respondents’ views about anonymity. If you know a respondent has been indiscreet in revealing confidential information, never take advantage.

18. If you wish to tape-record the interview, you must obtain permission from the interviewee.

19. Honesty and integrity are important.
APPENDIX 6

Letter of Explanation to Participants regarding the purpose of Questionnaire

(Date)

Dear ________________________,

As part of an evaluation of our Home Care service, which commenced in March 2009, I am carrying out a survey in order to determine your views of the treatment and care you received from the Home Care Team. In order to improve the service we offer to clients, we need to know how YOU, the Service User, view the service afforded you as a recipient of home care.

It would be very helpful if you would take the time to complete the survey questionnaire enclosed and return it to me before September 31st 2009 in the stamped addressed envelope provided.

This is a totally anonymous survey and while the information you give will be very helpful you are not obliged to respond. However, we would be very grateful if you would complete the questionnaire, as it is our aim to improve the service based on your views.

All information gathered will be treated in the strictest confidence. The information from this survey will be used for the sole purpose of reviewing the service provided to clients by the Home Care Team.

Thank you for your cooperation.

_____________________________
Madge Conboy-Browne
Nurse Practice Development Coordinator
Ms. Madge Conboy-Browne  
Nurse Practice Development Coordinator  
HSE Dublin Mid-Leinster  
Mental Health Services (Dublin South East)  
Dublin South East  
8 Vergemount Hall  
Clonskeagh  
Dublin 8

RE: Application For Permission To Carry Out An Evaluation Of Réimse Home Care Programme

Dear Madge,

I wish to inform you that the Management Team has granted permission to carry out an evaluation of the Réimse Home Care Programme.

The Management Team also discussed the patient survey forms and Dr. Freeda O’Connell (Clinical Director) said to omit the unnecessary questions on the form and, if not possible, form will need to be changed.

Sincerely yours,

Kathleen Beggan,  
Director of Nursing  

KB/kjl

29th June 2009