Carlton House

ID Number: RES0009

24 Hour Residence – 2018 Inspection Report

Carlton House
Lispoppel
Swords
Co. Dublin

Community Healthcare Organisation:
CHO 9

Team Responsible:
Rehabilitation

Total Number of Beds:
10

Total Number of Residents:
9

Inspection Team:
Siobhán Dinan, Lead Inspector

Inspection Date:
15 January 2018

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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Contents

Introduction to the Inspection Process

This inspection and report were guided by the themes contained in the Mental Health Commission Quality Framework.

Services will be aware of the Audit Toolkit deriving from the Quality Framework and may wish to consider using this Toolkit in pursuing service improvement within the residence involved.

Service description

Carlton House was a 24-hour, high-support, community residence located close to the village of Lispoppel, Co. Dublin. It was a two-storey, detached residence situated approximately 6 km from Swords. Carlton House had been functioning as a community residence for former patients of St. Ita's Hospital, Portrane, since 2000. It provided accommodation for nine residents under the care of the community rehabilitation team. There were seven bedrooms in total. One of the beds in a double room was vacant at the time of inspection.

The exterior of the residence was well maintained, and the house was surrounded by an extensive garden. The residence had been recently renovated. The renovation consisted of new paving in the back garden, new furniture in the dining room, and new flooring in one of the en suite bathrooms.

Residence facilities and maintenance

Residents in Carlton House were accommodated in three double and four single bedrooms, six of which had en suite bathroom facilities. There were two double rooms upstairs and one double and four single bedrooms' downstairs. There was no screening between beds in the shared rooms, which was not conducive to resident privacy. The en suite bathroom attached to one of the double bedrooms upstairs was malodourous.

The ground floor accommodation included a sitting room, a library/seating area, a kitchen and pantry, a dining room/activity room, and a sunroom, which doubled as a gym and games room. There was a large, well-maintained garden with a shed and smoking gazebo.

In recent times, the curtains in the residence had been replaced, new mattresses had been purchased, a new kitchen had been fitted, and new dining room furniture and chairs for the hall/office had been purchased. At the time of inspection, the flooring downstairs was in the process of being replaced.

Plans were in place for further refurbishments, including new flooring, painting, new furniture for the library area and sunroom, new bed bases, and one new shower.

Resident profile

Residents ranged in age from 45 to 66 years. At the time of inspection, two female and seven male residents were accommodated in the residence. The most recent admission occurred about one month prior to the inspection and one resident had been living in the residence since it opened in 2000. One resident had ward of court status and the remaining residents were voluntary. Three residents had a dual diagnosis of learning disability and mental illness. All residents were fully mobile.

Care and treatment

There was a policy on individual care plans (ICPs), which was last reviewed in October 2016. The consultant psychiatrist attended the residence monthly and the non-consultant hospital doctor attended weekly. All residents had an ICP. Care plans were reviewed on a six-monthly basis. Residents were involved in the care planning process and could attend their ICP review meeting. Residents completed a "My Care Planning" leaflet with their key worker before the ICPs were reviewed. Residents signed their ICPs and were offered copies.

Not all ICPs showed evidence of multi-disciplinary team (MDT) input. The clinical files evidenced medical, nursing, occupational therapy, and social work input but not psychology input. The inspector was informed that there had been a vacant psychology role on the team for some time. The MDT meetings were held weekly in the residence and residents could attend. The clinical progress notes were well maintained, up to date, and provided a clear account of each resident's progress, care, and treatment. A mental state examination was documented in the residents' files at least six-monthly. Nursing staff on-site functioned as key workers for the residents. Each resident had a consistent key worker and a deputy key worker assigned to them.

Physical care

Carlton House had a policy in relation to physical care/general health, which was last reviewed in January 2016. All residents had their own GP. Staff made appointments for residents to attend their GP and accompanied residents on GP visits if required. Physical examinations were undertaken by the GPs every six months or more frequently if needed, and these were recorded in residents' clinical files.

Information about national screening programmes was unavailable in the residence, but residents did have access to appropriate screening programmes. Other health care services were available to residents, including physiotherapy, dentistry, chiropody, dietetics, and speech and language therapy. The GP or a member of one of the admitting teams made referrals where necessary.

Therapeutic services and programmes

Carlton House did not have a policy in relation to the provision of therapeutic programmes. Residents did not have access to therapeutic programmes within the residence. A number of residents attended the DEVLIN programme and the REACH programme in the community daily. Residents were involved in social, recreational, and life skills training programmes here. Therapeutic programmes, including basic living skills, medication, health, recovery, budgeting, and Wellness Recovery Action Plan (WRAP) were available to residents through the DEVLIN and REACH programmes.

Recreational activities

Daily recreational activities delivered in the residence included bingo, word wheel, board games, TV and music, arts and crafts, and baking. Other activities such as gardening were also available to residents. There were organised outings several times a week, which included trips to the local shopping centre, the local hotel for a meal or to play pool, to cafés, the cinema, and for walks in Phoenix Park. Residents had access to exercise equipment and a mini pool table in the sunroom of the residence.

Medication

Carlton House had a policy in relation to medication management, which was dated January 2014. Medication was prescribed by the residents' consultant psychiatrist, a non-consultant hospital doctor, or their own GP. A Medication Prescription Administration Record (MPAR) system was in operation, and resident MPARs contained valid prescriptions and administration details. At the time of inspection, two residents were self-medicating and this was managed accordingly. Medicines were supplied by two local pharmacies and were stored appropriately and legally in a locked cabinet. Expired medication was identified in the medication fridge during inspection. There was no system of reconciliation and inventory of medication.

Community engagement

The house was situated in a rural area with some other detached homes nearby. There were no community facilities within walking distance. The isolated nature of the house and the infrequency of the bus service meant that residents found it difficult to travel independently. The residence had its own nine-seater vehicle, which was used to transport residents to community activities, including shopping, mass, and trips to the bowling alley and the cinema.

There was in-reach into the residence from the community from a hairdresser, who visited twice a month. In addition, a local priest and choir attended the house annually for a Christmas mass.

Autonomy

Residents had access to the kitchen in the house, but some needed assistance to prepare meals and snacks. Residents were free to determine their bedtimes and were encouraged good sleep hygiene. None of the residents had a key to their own bedrooms or to the front door.

Residents helped out with household activities, including laundry, kitchen duties, and cleaning chores. Residents could come and go as they wished and normally let staff know where they were going. Visiting hours were flexible, except at meal times.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager	1	0
Registered Psychiatric Nurse	1	1
Health Care Assistant	1	1
Multi-Task Attendant	1	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As requested
Social Worker	As requested
Clinical Psychologist	0
Dietician	Bi-annually

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Monthly
Non-Consultant Hospital Doctor	Weekly

Staff had received training in fire safety and the therapeutic management of violence and aggression. All staff were not up to date with training in Basic Life Support and had not been trained in recovery techniques.

Complaints

Carlton House used the HSE's *Your Service Your Say* complaints procedure. Residents were aware of how to make complaints, and notices explaining the complaints process were publicly displayed. Complaints were addressed in the first instance by nursing staff, or they were referred to the clinical nurse manager 2 or the complaints officer when they required escalation. A minor complaints log was not maintained; minor complaints were documented in the minutes of the weekly community meetings. There was a suggestion box in the hall of the premises.

Risk management and incidents

Carlton House had a policy in relation to risk management, which was dated October 2016. It also had a risk register dated May 2016, which was in the process of being updated. There was a safety statement and emergency plan, dated May 2016. The risk management policy was being implemented in the residence.

Residents were risk-assessed at admission, and their risk management plans were updated as necessary. Risk assessments were completed as risks were identified. Incidents were reported using the National Incident Management System, and copies of incident reports were retained in the residence.

The residence was physically safe. Fire extinguishers were serviced and in date, and fire escapes were easily accessible. There was a first aid kit in the kitchen and in the office.

Financial arrangements

Carlton House did not have a policy in relation to managing residents' finances. The charge for residents was means tested and included food and utilities. Some of the residents had bank or post office accounts, and others had their money managed by the accounts department in St. Ita's Hospital. Appropriate processes were in place in relation to staff handling residents' money. A cash lodgement book was maintained, all transactions were signed by two staff members, and receipts were kept.

Residents did not contribute to a kitty or social fund, and their finances were audited every three months by the assistant director of nursing and the clinical nurse manager 2.

Service user experience

The inspector greeted residents and explained the purpose of the inspection. Three residents spoke individually with the inspector. Each considered the residence comfortable and were satisfied with their care and treatment. The residents told the inspection team that the meals were very good, that they had input into the menus, and that their suggestions were always implemented. Residents were complimentary about the staff and said that they were friendly, kind and took good care of them.

Areas of good practice

1. An appointment folder was in operation so as to keep up with all residents' various appointments.

2. Each resident had a communication passport, which described their most effective means of communication and how others can best communicate with and support them.

3. The quality and care of residents was excellent.

4. Family members were invited to attend ICP review meetings with consent of residents.

5. Resident community meetings were held weekly with minutes recorded.

Areas for improvement

1. Any complaints, comments, or suggestions received by residents should be documented so that there is clear evidence that any issues arising are acted upon.

2. Each resident should have their own bedroom. In the meantime, privacy screens should be used where there are shared bedrooms.

3. Activity timetables on the noticeboard were in need of updating.

4. The multi-disciplinary team should be fully resourced to ensure that residents have access to a comprehensive range of therapeutic interventions.