Croí An Tobair

ID Number: RES0079

24-Hour Residence – 2017 Inspection Report

Croí an Tobair
Enniscorthy
Co. Wexford

Community Healthcare Organisation:
CHO 5

Team Responsible:
Wexford Area Rehabilitation Team

Total Number of Beds:
8

Total Number of Residents:
6

Inspection Team:
Dr Ann Marie Murray, MCRN 363031, Lead Inspector

Inspection Date:
17 August 2017

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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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

Croí an Tobair was an 8-bed, 24-hour, nurse-staffed residence located in Olyegate village, Enniscorthy, Co. Wexford. The residence was owned by the Wexford Mental Health Association but staffed and managed by the HSE, Community Healthcare Organisation (CHO) 5. It was a purpose-built, single-storey detached building, providing accommodation for six residents at the time of inspection. Croí an Tobair, which was officially opened in 2007, was a supervised residence, providing care for people with an intellectual disability. All of the residents were accommodated in single rooms.

The needs of the residents were primarily related to their intellectual disability. Just one resident had a documented diagnosis of mental illness. Despite this, the residents care and treatment was provided by a rehabilitation psychiatry team and not an intellectual disability service team. This rehabilitation psychiatry model of care did not meet the resident specific needs of service users with intellectual disabilities. The responsible consultant psychiatrist reported that the residents care should be provided by a mental health intellectual disability (MHID) team; however, there was no such team in place in CHO 5. There was no clear timeline for when an MHID team would be established.

Resident profile

Residents ranged in age from 45 to 73 years. At the time of inspection, there were four male and two female residents. Some residents had been living in Croí an Tobair since it opened in 2007, having transferred from St. Senan's Hospital. One resident was a ward of court, and the others were residing there on a voluntary basis. All of the residents' primary diagnosis was that of an intellectual disability. Just one resident had a documented mental illness. There was a wide range of intellectual disability among the service users, ranging from mild intellectual disability to severe/profound intellectual disability. Residents had a wide range of additional needs including communication issues, sensory difficulties and impairments, and co-morbid physical difficulties.

Care and treatment

Croí an Tobair had a policy with regard to individual care plans (ICPs), and all residents had an ICP. The ICPs were typed up and detailed. Multi-disciplinary team (MDT) input into ICPs was limited. There had been no psychology input for three years due to recruitment issues. There were frequent apologies at MDT meetings from social work and occupational therapy meaning that residents rarely had the input from the entire MDT into their ICP.

The MDT met twice a year in the residence and reviewed residents' ICPs. Residents and family members were encouraged to have input into the ICPs at the MDT meetings. Psychiatric evaluations were documented at least six-monthly as part of the ICP. There was a key worker system in place, which involved the nursing staff only. The MDT responsible for the care and treatment of the residents was a psychiatric rehabilitation team. The residents did not have access to a specialist intellectual disability team. There were plans to train nursing staff in the behavioural support of residents. At the time of the inspection, none of the residents had a behavioural support plan.

Physical care

Croí an Tobair used the CHO 5 policy in relation to physical care/general health. All residents had access to a local GP. Routine physical examinations were completed by a psychiatric registrar on a six-monthly basis. No information about screening programmes was displayed in the residence, but residents had access to appropriate screening programmes. Other health care services were available to residents, including a dentistry, chiropody, optical (in Enniscorthy), dietetics, speech and language therapy, physiotherapy, and occupational therapy. Residents could also access general health care in Wexford General Hospital and through local outpatient services.

Therapeutic services and programmes

Croí an Tobair used the CHO 5 policy in relation to the provision of therapeutic programmes. Residents had limited access to therapeutic activities. There had been clear efforts from the MDT to engage residents in therapeutic activities, however it was evident that the resources available to staff were not directed towards the very specific needs of residents with an intellectual disability. Half of the residents attended Killagoley Training & Activation Centre (KTAC); however, this service was focused on the needs of service users with a mental illness. Of the residents that did attend, there was limited evidence of meaningful engagement in the activities available.

At the time of inspection, a music exploration officer had been appointed by the Wexford Mental Health Association (funded by HSE). This was a time limited pilot intervention that occurred in the centre. Staff reported that residents appeared to meaningfully engage in this and were hopeful about continuing this

programme in the longer term. There were plans for staff to collaborate with residents on a horticulture project. The residence had a multi-sensory Snoezelen room that was not used regularly by the residents.

There was limited opportunity for residents to engage in life skills such as cooking and cleaning. All meals came from a central kitchen in St. John's in Enniscorthy, so residents were not involved in meal preparation. An occupation therapy needs assessment had taken place in 2017. The report from this had identified potential areas for intervention for residents; however, these goals lacked specificity with no clear guideline of when these interventions would occur. It was referenced that these interventions may occur when a mental health intellectual disability team was in place. There was no clear idea of when or if this team would be in place.

Medication

Croí an Tobair used CHO 5 policy in relation to medication management. Medication was prescribed by the residents' GP, the consultant psychiatrist, or the psychiatric registrar. A Medication Prescription Administration Record (MPAR) system was in operation, but a number of omissions were identified on inspection. In one MPAR, the Medical Council Registration Number (MCRN) of the prescribing physician was illegible. In one MPAR, the allergy section was not completed, and there were blanks in the administration record in two MPARs.

Medicines were supplied by a local pharmacist. Requests for medication were faxed to the pharmacy, which delivered the order. Medications were checked on arrival by nursing staff. Non-medication items were stored in the medication press. Staff were advised to remove these from the press. Residents did not manage their own medication, and no resident was self-medicating.

Community engagement

The location of the residence facilitated community engagement. The residence was close to shops, the local church, and the village and was within easy reach of Enniscorthy and Wexford town. Residents had very little involvement in community activities however, and there was limited community in-reach to the residence. The residence had a five-seater bus for transporting residents.

Autonomy

Croí an Tobair was a locked unit, and residents could not come and go from the facility as they wished. Residents were identified as being at risk of wandering and had poor road safety awareness. All residents required accompaniment on trips out. Residents did not have free access to the kitchen area because staff identified risks associated with scalding, cleaning products, and overeating. There was minimal support available to residents to engage in food preparation or domestic activities such as weekly shopping and maintenance of the residence. Residents were free to receive visitors at any time.

Residents were free to determine their own bedtimes. Only two of the residents had keys to their own bedrooms. There were thumb locks on the outside of residents' bedroom doors with the key lock on the inside of the door. This meant that if they had locked their bedroom door, any resident could open the door from the outside and enter. This was discussed with staff and it appeared that the locks had been put on the wrong way around. All resident wardrobes were locked due to a risk staff had identified in relation to one resident. This meant that residents had to approach staff to access their wardrobe. Soap was also not provided to residents in some of the bathrooms due to an identified risk; however, this was inconsistently implemented throughout the centre with many of the bathrooms providing soap. These restrictive practices, including the rationale for the practices had not been subject to review.

Residence facilities and maintenance

Croí an Tobair was a purpose-built, attractive building with double height ceilings in parts. It was set in a housing estate in the small village of Oylegate, between the towns of Enniscorthy and Wexford. There was no signage at the gates of the unit; there was a sign at the door. Bright flowerpots in bloom were at the entrance to the building. Croí an Tobair was clean and well maintained.

Residents had access to a garden area. According to staff, this space was under-utilised by residents. There was a large unsightly pole in the garden and no areas of focus or interest. The service had its own back-up generator, which was located in the resident garden area. This was also unsightly. Plans were in place to improve the garden area for residents. There was a polytunnel, which in the past had been used by residents to grow produce. This had fallen into disrepair and was largely overgrown. Staff had recently begun to clear this out with hopes of involving residents in the growing of fresh produce.

Residents were accommodated in single bedrooms, which had adequate wardrobe and locker space for the storage of personal items. The residents' bedrooms were sparsely decorated and lacked personal touches. There were large clear observation panels in the doors of each resident's room. There was no screening on this observation panel. Residents could potentially be observed in their bedroom when engaging in or receiving personal or intimate care. This did not respect residents' right to privacy.

There was an adequate number of shared, universal access bathrooms for residents; however, some of these did not contain hand soap for resident use. One of the shared bathrooms had a shower chair, which was black and covered in mould. Nursing staff had reported this to maintenance over a year ago and it had not

been replaced, but staff had continued to use this chair. Staff were advised to cease using this chair and to consider alternative options.

There was a kitchen area and a small dining room. The kitchen area was not large enough to incorporate a freezer. The freezer was stored separately in a storage room. Temperatures were not checked and recorded on the freezer but were recorded for the fridge in the kitchen.

Residents had access to a large, bright sitting room with double height ceilings. The sitting room had a large screen TV, comfortable furnishings, and an exercise bike. There was a multi-sensory, or Snoezelen, room. There was a designated visitor bathroom. There was a laundry room and a storage room. There was a small nursing office, which contained the medication trolley and medication press. There was no dedicated clinical room. A recent environmental health officer inspection had recommended a sluice room for the centre.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager	0-1	0
Registered Psychiatric Nurse	1-2	1
Health Care Assistant	1	1
Household Staff	1	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	Twice a year and when required
Social Worker	Twice a year and when required
Clinical Psychologist	None

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Twice a year and when required
Non-Consultant Hospital Doctor	Twice a year and when required

Staff had received fire safety training but were not up to date with training in Basic Life Support or the management of violence or aggression. Three staff had received training in working with people with an intellectual disability. Certificates of training in working with people with an intellectual disability were provided to the assistant inspector, one of which indicated training had occurred 17 years ago. None of the staff were trained in Lamh, a manual sign system used by children and adults with intellectual disability and communication needs in Ireland, despite some residents having significant communication difficulties.

Complaints

Croí an Tobair had a complaints policy. The complaints process was detailed in posters on display in the residence, but the process was not explained in a format that the residents could understand. Minor complaints were addressed locally or, where necessary, escalated to the clinical nurse manager 2. There was a nominated complaints officer, and there was a suggestion box. There was a complaints log in the residence at the time of inspection, but no complaints were documented. No community meetings were held in the residence.

Risk management and incidents

Croí an Tobair had a risk management policy, which was implemented throughout the residence. Risk assessments were completed for residents, including falls assessments, and risk was addressed as part of the ICP meetings.

Incidents were documented and reported. The majority of incidents related to slips, trips and falls, and incidents of violence and aggression. Incidents were escalated to a Quality and Safety Executive Committee where necessary. Fire extinguishers were in date, and fire escapes were easily accessible. First aid supplies were available in the nursing office.

Financial arrangements

The residence had a policy in relation to managing residents' finances. The weekly charge for residents was €155, which covered accommodation, food and utilities, and chiropody. Residents' pensions or disability payment were lodged into a patient property account managed in St. Senan's Hospital. Money was withdrawn by staff from the account weekly for each resident, and small sums were kept in the residence. Receipts were issued for all transactions. Residents' finances were audited internally and externally every three months. There was no communal social fund or charge.

Service user experience

The assistant inspector met with residents throughout the inspection. Residents who had verbal ability praised the staff and the support they received from them. Residents with more severe intellectual disability and communication difficulties were observed to be frustrated when trying to express themselves to the nursing staff. Nursing staff were observed to attempt to understand the residents; however, there was a lack of augmented communication techniques such as visual boards or sign language used. A communication passport template was used by the service to document the residents preferred means of communication and to inform staff of how best to communicate with residents.

Areas of good practice

1. Clear efforts from members of MDT to engage residents in therapeutic activities but lack of training for staff in how to meet the needs of residents with intellectual disabilities may have limited the success of these attempts.

2. External audit of residents' finances on a three monthly basis.

3. Introduction of pilot music therapy intervention.

4. The internal premises were clean and well maintained.

5. ICPs were typed and clear to read.

Areas for improvement

1. As residents' needs related to their intellectual disability, it was not appropriate that the mental health service provide care and treatment to this population of residents. The residents should be more appropriately cared for by social care/disability model of care.

2. Staff providing care to these residents should have training in how to meet the specific needs of residents with intellectual disabilities.

3. There was no review or oversight of restrictive practices, which were many.

4. While the premises were well maintained there were a number of areas that could be improved:

   (a) Consider personalising the decoration of residents' bedrooms.
   (b) Develop the garden area for residents.
   (c) Replace black mouldy shower chair.
   (d) Consider putting locks on bedrooms the right way around.
   (e) Privacy screens on observation panels of residents bedroom doors.

5. Residents rarely had input from the entire MDT into their ICP.

6. There had been no psychologist in post for three years.

7. There is a need to monitor freezer temperatures.

8. As there were omissions in the MPARS, staff should consider training or audit in this area.

9. Consideration should be given to starting community meetings for residents.