Grace Park

ID Number: RES0025

2017 24-Hour Residence Inspection Report

Grace Park
Dublin 9

Community Healthcare Organisation:
CHO 9

Teams Responsible:
Rehabilitation
Community Mental Health

Total Number of Beds:
10

Total Number of Residents:
10

Inspection Team:
Orla O'Neill, Lead Inspector
Donal O'Gorman

Inspection Date:
12 April 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

Grace Park was a 24-hour nurse-staffed community residence in the Drumcondra area, located in a quiet residential cul-de-sac. This three-storey, red-brick terraced residence consisted of two adjacent houses, which had been amalgamated into one unit. One of these houses was privately owned and was leased by St. Vincent's Hospital, Fairview, and the other house was directly owned by the HSE. This led to inconsistency in terms of maintenance and upkeep and the central heating in each house.

Grace Park accommodated long-stay residents with significant and enduring mental illness. Residents were under the care of multi-disciplinary teams from St. Vincent's Hospital, Fairview. These comprised a rehabilitation team and three Community Mental Health Sector teams based in St. Vincent's Hospital. Most of the residents had been in Grace Park for a considerable period of time.

Care and treatment

Currently, residents were under the care of either the rehabilitation team or a community sector team. The treating teams did not come to Grace Park. Residents were psychiatrically reviewed in the out-patient service. The frequency of review in the out-patient clinics was variable, depending on individual resident need. The clinical files in Grace Park contained a log sheet at the front, which presented a dashboard overview of the medical appointments, both psychiatric and physical health, attended by each resident. While this presented useful data on the frequency and range of appointments, there was inadequate information recorded to provide a clear and up-to-date status report on the residents' well-being. For example, one resident's file had an entry in 2015 and no evidence of a physical or psychiatric review recorded since then. The last recorded psychiatric review for another resident was dated 2015. One clinical file contained a referral letter to the HAIL supported housing organisation in 2016, but no follow-up information was recorded to indicate the outcome. This was not to say that physical and psychiatric reviews were not taking place. The issue was that information was not being transcribed into the Grace Park clinical files, and consequently the key worker and nursing staff there did not necessarily have a fully informed picture of the residents' health status. Nursing staff would telephone the treating team or the on-call non-consultant hospital doctor if an immediate psychiatric review was required for a resident in Grace Park.

Nursing care plans were in place for all residents and were reviewed regularly. Eight residents had an individual care plan (ICP) documented in their clinical file. The ICPs evidenced medical and nursing input, with little evidence of input from occupational therapy, social work, or psychology. The ICP documentation was generally completed by the nursing staff in Grace Park. The pro-forma ICP document made provision for recording comprehensive domains of care appropriate to rehabilitation residents. The frequency of ICP review was variable.

Physical care

All residents had their own GP, dentist, chiropodist, and optician. The community residence did not have a uniform approach for residents to have a physical examination. Nursing staff in the community residence organised physical reviews either via the residents' own GP or if they required referrals to general hospital (Mater Hospital) for physical/medical review. Also, physical reviews were completed by the residents' own treating multi-disciplinary team (MDT) i.e. the residents' rehabilitation or community mental health teams. Four clinical files examined during the course of the inspection indicated that comprehensive physical/medical review and six-monthly physical reviews were completed. Nursing staff reported on inspection that residents were reviewed regularly by their GP. Nursing staff and the residents' GPs provided information to residents about screening programmes. Three of the clinical files inspected recorded Breast Check in 2015 and Bowel Screen 2015, and Diabetic Retinopathy 2015 screenings. Physiotherapy, speech and language therapy, and dietetics referrals were made by the GP or the treating mental health team.

Overall, the clinical files held within the residence did not have systematic documentation of the undertaking of regular physical reviews and there was no system apparent to remind staff that such reviews were due.

Therapeutic services and programmes

The community residence had an up-to-date policy on therapeutic programmes and services. The daily operation of the residence was coordinated by nursing and care staff. There was little evidence of input from other disciplines. There was no schedule of therapeutic programmes within the residence. Several residents went out to therapeutic programmes in external facilities. Two residents went to the Basin Club, one resident went to a men's shed, six residents went to St. Lawrence's Road Day Centre, and one resident attended the Recovery Hub on the North Circular Road. No residents were attending vocational support or training services. The clinical files did not evidence recent input from health and social care professionals on-site.

It was apparent that staff were interested and actively engaged with the residents and were supportive in assisting them to engage in both social and recreational and community mental health services. There was a schedule of recreational activities posted up in the residence. Activities supported within the residence included beauty care, music, art, and table games. Nursing staff had access to the St. Vincent's Hospital Fairview bus and staff facilitated outings for the residents.

Medication

Medication was prescribed either by GP or by the responsible mental health team. A Medication Prescription Administration Record (MPAR) system was in operation. Eight MPARs were inspected. All MPARs contained medical council registration numbers, medication start/stop dates, as needed/as required sections, and allergy sections. Each recorded appropriate resident identifiers, which included name, date of birth ,and medical record numbers. The generic names of medication were appropriately documented. All the MPARs inspected were well written and legible.

Medicines were supplied by a community pharmacy and were held in a locked clinical room. Residents did not manage their own medication and there was no resident in the residence who was self-medicating. During the inspection, nursing staff reported that they would provide residents with information on their medication if required. However, no medication-related information in a user-friendly format was readily available.

Community engagement

Drumcondra village was a short distance away and residents availed of coffee shops, hairdressers, barbers, and churches. A small number of residents enjoyed family support and went out with family members. Staff were encouraging and supportive of residents getting involved in community activities and had compiled a folder of free amenities and activities in Dublin. Due to the long-standing nature of their illness and increasing dependency, many residents did not initiate community activities.

Autonomy

All meals were prepared and cooked by a multi-task attendant and, outside of this. by nursing staff. There was a limited choice of meals but residents' preferences were taken into account insofar as practicable.

Residence facilities and maintenance

In both House 4 and House 5, there was little evidence of recent decoration or routine maintenance. House 4 had a small outdoor area, which was paved, but this area was cordoned off for staff, residents, and visitors as a number of roof tiles had fallen off the roof, leading to a health and safety risk. House 4 had a comfortable sitting room with nice furniture, a plasma television, a music system, and a book shelf with a number of books and magazines. Residents also had access to a public payphone or could have their own mobile phones.

House 5 had a large outdoor area, which was primarily used as a smoking area for residents. It also housed the laundry facilities (in an outside shed), which included two washing machines and separate drier. This facility was open and the shed required upgrading and renovation. There was also a comfortable sitting room in House 5, which included large plasma television, an assortment of books, magazines, DVDs, and a music system. Both sitting rooms were homely, comfortable, and welcoming.

The dining room area was divided into two separate sections, which was functional. The kitchen area was clean and well stocked with foodstuffs and catering equipment. Meals were prepared by the chef from Monday to Friday, and multi-task attendants prepared the meals over the weekend. Mealtimes were displayed and residents had an adequate amount and choice of food.

Resident accommodation was a combination of single and twin rooms located on all three floors. Each resident had an individual wardrobe, cupboards, and lockable bedside lockers. Twin bedrooms had inadequate provision for personal privacy, with no privacy curtain in place between both bed spaces. A number of residents had personalised their bedrooms with photographs and paintings. The overall standard of the bedroom accommodation was poor. Storage space was limited in both houses and many of the residents' bedrooms had excess clothing and personal property and possessions stored on the floor.

Toilets and bathrooms were located at various points throughout the premises. The upstairs toilets/bathrooms were unclean in appearance, with loose and broken lino on the floors. Bathroom areas could be locked and, if necessary, locks could be overridden by staff.

The overall décor and maintenance of the residence was poor. There was exposed electrical wiring on one of the exit doors, which had a temporary cover over the wires. A number of bedrooms and communal areas were in need of repainting, with existing paintwork stained, peeling, and badly discoloured. There were no curtains or blinds in the dining areas. A number of window frames and windows were in significant need of renovation and upgrading. Both houses were warm and adequately heated and ventilated.

Staffing

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	-
Social Worker	-
Clinical Psychologist	-

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

Complaints

The community residence used the HSE "Your Service, Your Say "complaints process. Residents were aware of how to make a complaint. Resident complaints were initially raised and brought to the attention of the CNM2 and/or raised via the monthly community meetings forum. The CNM2 in the community residence addressed and dealt with complaints at a local level where possible; unresolved complaints were then recorded and escalated to the assistant director of nursing/complaints officer in St. Vincent's Hospital, Fairview, depending on the nature of the complaint. There was no actual complaints log or suggestion box; however, following inspection of the community meetings minutes, there was documented evidence of complaints being made by residents and same being addressed by the nursing staff within the residence.

Risk management and incidents

There was a risk management policy in place and a defined system for reporting, managing, and investigating incidents. Individual risk assessments had been completed for all residents. There was a need to update some risk assessments in response to the changing needs of residents. There had been no notable incidents in the residence. The unsafe condition of the roof, with tiles falling off into the garden area, had been identified as a risk. Remediation work had not been completed and the main garden area was out of bounds for residents.

Financial arrangement

The residence did not have a specific policy on managing residents' finances. Residents held their own monies in the post office or personal bank accounts, or their monies were held in a trust fund into which disability benefits were paid. Residents accessed their own monies via the post office, and some residents had ATM cards. All residents were charged a flat rental of €90 per week, which covered accommodation, food, and utilities. The same rate was payable by residents in a single and in a shared room. The residence did not have any communal social fund.

Service user experience

No service user expressed a desire to meet with the inspection team on an individual basis. A number of residents, who were greeted during the course of the inspection by the inspection team, expressed their satisfaction with staff and the routine within the residence.

Areas of good practice

1. The individual clinical files contained a log sheet, which provided a dashboard overview of all physical and psychiatric appointments attended by a resident.

2. The pro-forma individual care plan document contained headings appropriate to residents in a rehabilitation service.

Areas for improvement

1. A health and safety audit of the premises should be completed by an appropriately qualified person.

2. Refurbishment of the premises is required.

3. Single room accommodation should be provided for each resident.

4. A review of the communication and recording processes should take place to ensure the residents' clinical files contained an adequate and up-to-date account of the discussions and outcome of resident psychiatric reviews and MDT meetings held off-site.

5. A rationalisation of the ICP documentation should take place to ensure each resident had a single MDT ICP document.

6. A review of therapeutic opportunities for residents should take place to maintain basic living skills such as cooking and shopping and to include and assessment of the suitability of the kitchen premises.