O'Connell House

ID Number: RES0052

24 Hour Residence – 2017 Inspection Report

O'Connell House
Co. Limerick

Community Healthcare Organisation:
CHO 3

Team Responsible:
Rehabilitation

Total Number of Beds:
18

Total Number of Residents:
17

Inspection Team:
Dr Enda Dooley MCN004155, Lead Inspector
Martin McMenamin

Inspection Date:
16 August 2017

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
20 April 2018

Contents

Introduction to the Inspection Process

This Inspection and Report was 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

O'Connell House was a large, purpose built, community residence which was located within a town and adjacent to a variety of community therapeutic and social resources. The residence was approximately 30 years old and was owned by the HSE. It consisted of a rectangular, single story accommodation which surrounded an internal garden. The residence was located on a public road within the town. It was managed by the Rehabilitation team. At the time of this inspection the residence had 18 beds and was accommodating 17 residents. Currently 14 residents occupied bedrooms on a single occupancy basis (in some cases a single resident occupied a room originally designed for three people). None of the bedrooms had en suite facilities. The residence functioned as a rehabilitation facility.

Resident profile

There were 12 male and 5 female residents living in the house. The residents ranged in age from 35 to 80 years with the majority over 60 years. The most recent resident had been five months in the house and some residents had spent over 25 years living in O'Connell House. All residents were voluntary and one was a ward of court. All were independently mobile though one resident used a frame for assistance. Two residents had special needs in that they had a history of intellectual disability.

Care and treatment

The residence utilised the generic service policy on care planning. All residents had an individual care plan (ICP) which was maintained in conjunction with assessments utilising the CASIG (Client Assessment of Strengths, Interests, and Goals) assessment tool. ICPs were reviewed approximately every six months on average. The multi-disciplinary team (MDT) met in the residence approximately every month. All residents had a keyworker and associate key worker. Prior to ICP review the keyworker would meet with the resident to review progress and agree priorities. The resident was encouraged to attend and input to the ICP review. Residents had access to the team during Multi-Disciplinary Team reviews or, if the need arose, staff could accompany the resident to Limerick for review.

Physical care

The residence used the service policy in relation to the organisation and provision of physical care. All residents were registered with a local GP practice. It was policy to refer all residents to the GP for a full physical review at least every six months. These were documented in the clinical file. Where the resident was invited to partake in relevant national screening programmes the keyworker would discuss this with the resident and encourage him/her to partake. Written information on screening programmes could be provided. A number of residents were engaged in national screening programmes. The location of the residence facilitated access to other health services. Residents could attend a local dentist and access to physiotherapy services was available through the local community hospital which was adjacent to the residence. If a resident required speech and language assessment this was obtained privately. Access to secondary medical services was through University Hospital in Limerick which was over 30 kilometres away. Similarly, dietetic services were accessed through the general hospital.

Therapeutic services and programmes

Nursing staff based in the residence provided exercise and activation sessions to residents. Staff indicated that there was no occupational therapy (OT) input to the residence to facilitate therapeutic programmes. In addition to activities based in the residence, residents had access to a day centre located next door (Maple Lodge) where a variety of therapeutic activities were provided; to an adjacent HSE horticulture centre (Gortboy); and to a nearby community resource (Desmond Centre) where social activities and other community supported activities were organised.

Medication

Medication management processes were governed by the generic service policy. All residents had an individual Medical Prescription and Administration Record (MPAR) which documented the prescription and administration of medication to residents. Medication was prescribed either by the psychiatrist or by the GP. Medications were supplied by a local community pharmacy in individual blister pack format on a two-weekly basis. Medications were stored in a locked pharmacy room within the residence and each resident's personal medication was stored individually. No current resident was self-medicating. Resident MPARs were reviewed and it was noted in a number of instances that documented prescriptions did not include the prescriber's signature or the Medical Council Registration Number (MCRN), as required by law.

Community engagement

The location of the residence facilitated engagement with the surrounding community. A number of residents attended local social and sporting events. In addition, residents were able to use local shops and to attend mass locally. While the residence did not have its own transport staff indicated that it was possible to book HSE transport for outings, etc. Residents could use HSE transport (by arrangement) or local public transport (taxi) to attend hospital or other events in Limerick or elsewhere. Staff interviewed indicated that apart from regular visits by a local minister of the Eucharist and the occasional celebration of mass within the residence the only regular community in-reach was by a visiting hairdresser. Staff indicated that intensive efforts had been in train, with some success, over the last year or so to familiarise the local community with the nature and purpose of the residence.

Autonomy

The front door of the residence was kept locked and residents had to approach staff to exit the building or ring a door buzzer to gain entrance. Staff indicated that this limitation in resident autonomy was deemed necessary as a number of residents were at risk of leaving the building and wandering. Residents did not have access to the kitchen to prepare personal meals or snacks. Residents were free to determine their own bedtime. Residents did not have a key to their own bedrooms but could request staff to lock the rooms, if desired. Some residents assisted with domestic activities within the house, including obtaining daily newspapers and other small shopping chores. Residents were encouraged to undertake their own personal shopping, including for personal clothing. If necessary staff would assist with this. While the resident information leaflet specified visiting times staff indicated that visiting was flexible. The residence had a visitor's room which could be used to facilitate private visits by family or friends.

Residence facilities and maintenance

The residence comprised a rectangular, single floor building surrounding an internal garden area. Access was by a locked front door which faced the street. The residence had two sitting rooms the larger of which had seating for 14 and was comfortably furnished with personal photos and effects. TV and radio were available. The residence had a Snoezelan room that, at the time of this inspection, was in the process of being re-located and re-furbished within the building. Some toilet and shower facilities were cramped and unsuitable for the age and gender cohort with inadequate provision for privacy and dignity. One bedroom had a glass panel in the external door which had no screening and did not facilitate the privacy and dignity of the resident using this room. One large bedroom was shared by three residents at their own request and adequate screening was in place to facilitate privacy. In other cases residents who, for clinical reasons, required single bedroom occupancy were facilitated by being located in what was previously a three-bedded room. In a number of cases adjoining bedrooms shared a toilet.

The internal garden area was in the process of being re-developed with the provision of walking and hard-core areas.

A second sitting room located at the rear of the building was dark and gloomy and required significant refurbishment to make it suitable for purpose.

One side of the building predominantly functioned as office and storage space and contained a laundry room. While this was available to residents it tended to be used by staff to clean domestic laundry. This corridor also contained a treatment room (only used by the chiropodist), a clinical room (which was available for the GP if required), and the visitors room. The dining room was bright and well lit with access to the garden area. It had adequate seating for all residents. While the residence was generally clean and reasonably maintained it was somewhat dated and institutional.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager 2	1 (M-F)	-
Registered Psychiatric Nurse	4	3
Health Care Assistant	-	-
Multi Task Attendant	5 (M-F); 3 (SS)	

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	Monthly MDT meeting
Social Worker	Monthly MDT meeting
Clinical Psychologist	Monthly MDT meeting
Other (specify	Art therapist (intermittent)

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Every 3 to 5 weeks
Non Consultant Hospital Doctor	Every 3 to 5 weeks

Complaints

The residence used the service complaints policy which was based on the HSE national policy "Your Service, Your Say". Notices within the residence and in the information booklet outlined the process for making complaints. There was a suggestion box located within the residence. Complaints were initially addressed by the Clinical Nurse Manager 2 in charge. If necessary, they could be escalated to the Assistant Director Of Nursing and to the Complaints Officer who was located in Limerick. The residence did not have a complaints

log to document any complaints arising and to clarify the outcome of any compliant. Community meetings were held weekly on a Sunday and minutes were kept.

Risk management and incidents

The service risk management policy applied to the residence. The residence had a dedicated risk register which was reviewed and updated on a quarterly basis. Residents had a risk assessment undertaken which was reviewed at their six-monthly MDT review. The CASIG was reviewed every 12 – 18 months. Incidents were reported using the National Incident Management System (NIMS) and were forwarded to the ADON and risk advisor for review and collation. The residence was on a single ground floor level and was physically safe. Plans were in train to provided ramps at the entrance area to facilitate access by residents who might have impaired mobility. Fire safety training was undertaken and all fire extinguishers were in date. Fire escapes were clearly marked and readily accessible. The residence had a defibrillator and an emergency kit available.

Financial arrangements

Financial practice within the residence was governed by the service policy on financial management. All residents had been individually assessed in relation to rental charges. Residents paid a weekly rent of between €80 and €175 depending on personal circumstances. €55 was retained for food and other necessities and the remainder was remitted to the finance department in St. Joseph's, Limerick. A number of residents had personal post office accounts and managed their own finances. In other cases, the Clinical Nurse Manager 2 (CNM2) acted as an authorised agent for the management of individual resident finances. In some cases, a family member managed resident financial affairs and would remit monthly amounts in cash to pay the resident's rent, etc. It was not routine for staff to issue a receipt for these cash amounts received on behalf of residents.

All residents had a personal wallet within the residence and withdrawal of funds required the signature of the resident and a member of staff, or alternatively of two members of staff. All use of resident monies for personal purposes involving staff required retention of supportive receipts. The residence did not operate any form of shared kitty or social fund.
Regular audits were undertaken concerning resident finances and an external audit by external staff was undertaken every 1-2 months.

Service user experience

A number of residents were met informally by the inspectors during the course of this inspection. No specific issues of concern were raised. Residents were appropriately dressed in clean personal clothing. Staff engaged appropriately with residents.

Areas of good practice

1. Since last inspected a greater proportion of the resident population have access to single room occupancy.

2. Residents have ready local access to a range of therapeutic and social outlets.

3. Steps are in train to improve engagement with the local community.

4. The garden area is in the process of being re-furbished to provide a recreational and therapeutic outlet throughout the year.

Areas for improvement

1. While espousing a Rehabilitative ethos residents had limited personal autonomy within the residence. Residents did not have personal control over access or egress from what is their home. Within the house the residents had limited privacy and facilities for the promotion of personal dignity were lacking.

2. Processes for the management of administration of medicines require urgent review to ensure that legal requirements in relation to the authorisation of medication provision and administration are observed.

3. All financial transactions, including the acceptance of specific amounts of cash from relatives should be receipted so as to protect staff from any potential accusation of malpractice.

4. The residence should maintain a complaints log to document any complaints received and managed locally.

5. Areas of the residence require significant refurbishment to maximise their utility as a rehabilitative resource and to provide a dignified living environment for residents.