Oak Grove

ID Number: RES0040

24-Hour Residence – 2017 Inspection Report

Oak Grove
Co. Galway

Community Healthcare Organisation:
CHO 2

Team Responsible:
Intellectual disability

Total Number of Beds:
8

Total Number of Residents:
8

Inspection Team:
Donal O'Gorman, Lead Inspector

Inspection Date:
20 July 2017

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

Oak Grove, an 8-bed, 24-hour nurse-staffed residence, was located in an urban area on the periphery of Ballinasloe town. The residence was owned and managed by the HSE, Community Healthcare Organisation (CHO) 2. The residence was a large, two-storey detached building, located in a private, reasonably well maintained area, with ample parking and space around it. The residence was situated in the grounds of the old St. Brigid's Hospital campus and was the last remaining operational building on-site. The residence was originally built and established as a home for the St. Brigid's Hospital campus priest and later became a residence for the clinical director of the hospital. Since the mid-1990s, it had been managed by the HSE. Oak Grove was a supervised residence providing mental health care for people with an intellectual disability. The area was served by public transport and was within easy walking distance of Ballinasloe town and all its amenities.

Resident profile

Residents ranged in age from 37 to 89 years. At the time of inspection, all residents were male and had an intellectual disability. The most recent admission was in 2014, and one resident had been living in Oak Grove since 1995. One resident was a ward of court. Two residents required full nursing assistance with their activities of daily living, including mobility.

Care and treatment

The treating consultant psychiatrist attended the residence weekly. Oak Grove had a policy with regard to individual care plans (ICPs), and all residents had an up-to-date ICP in place. Each resident had a designated key worker who was responsible for updating the ICPs on a six-monthly basis or as the need arose in conjunction with the residents. A sample of ICPs was inspected. These were a composite set of documents and were up to date. Input into the ICPs was primarily nursing and medical, with some input from psychology, occupational therapy, and social work. There was minimal evidence of residents' family/representatives having input into the ICP process. Psychiatric evaluations were documented at least six-monthly. Multi-disciplinary team (MDT) meetings occurred weekly but not within the building. They were held in St. Joseph's

activation centre, which also served as a day service training centre and a base for administrative/clerical staff and community mental health teams. There was no clinical nurse manager 2 (CNM2) attached to Oak Grove. The CNM2 who had responsibility for three community residences (including Oak Grove) within CHO 2 attended the weekly MDT, following a verbal update from nursing staff on Oak Grove's residents' current care and progress. Residents did not attend the MDT meetings. Staff had good knowledge of each resident's goals and current programme of care.

Physical care

Oak Grove had a policy on the physical care of residents. All residents had access to a GP and general physical examinations were completed on a six-monthly basis. The clinical files inspected showed comprehensive physical/medical reviews of the residents, with all residents having, at a minimum, vital signs' monitoring, weight charts, regular blood tests, and GP visits. Nursing staff reported that residents were reviewed regularly by their GP. No information about screening programmes was displayed in the residence. The residents' GP made referrals as appropriate for national screening programmes and for general health services such as speech and language therapy, tests and investigations, and specialist consultations. Overall, the clinical files in the residence did not systematically document the undertaking of regular physical reviews and there was no apparent system in place to serve as a reminder that such reviews were due.

Therapeutic services and programmes

There was a documented policy on therapeutic programmes for Oak Grove. The daily operation of the residence was coordinated by nursing and care staff. There was no schedule of therapeutic programmes displayed within the residence. Several residents went out to therapeutic programmes in an external facility – St. Joseph's activation centre – located in close proximity to Oak Grove. Both music therapy and art therapy were provided to residents once weekly in the activation centre. It was apparent that staff had good knowledge of each resident's goals and current programme of care and were interested to support residents' active engagement in therapeutic and social activities. However, minimal resources were available within the residence to provide this.

Medication

There was a policy on medication management. Medication was prescribed by the GP or the consultant psychiatrist; there was no non-consultant hospital doctor working with the MDT. A Medication Prescription Administration Record (MPAR) system was in operation. Eight MPARs were inspected. All MPARs contained the medical council registration numbers of those prescribing medication. Start/stop dates for medication were recorded, and MPARs included an as-needed/as-required section. The allergy section was not completed in two of the MPARs inspected, and the appropriate use of the generic names of medication was not included in one MPAR inspected. The use of a minimum of two resident identifiers, including name, date

of birth, and medical record numbers, was evident on all MPARs. All of the MPARs inspected were well written and legible.

Medicines were supplied by a local community pharmacy and held in a locked cupboard within a lockable nurses' stations. 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, but no medication-related information was available in a user-friendly format. Nursing staff had up-to-date training in Basic Life Support.

Community engagement

The location of the residence facilitated community engagement. Residents attended the local activation centre and the residence was in close proximity to Ballinasloe's shops and amenities. Some of the residents attended the local church weekly for mass and the local parish priest visited the unit. There was no community in-reach to the residence. Due to the nature of their illness and dependency levels, many residents were not involved in community activities.

Autonomy

Residents did not have free and full access to the kitchen area within the residence. All meals were cooked by health care assistants. Staff facilitated residents' access to hot/cold drinks and snacks. Residents did not have keys to their own bedrooms. Residents were free to determine their own bedtimes. Due to the population profile, residents infrequently assisted with household or domestic duties. Residents were free to receive visitors at any time. The residence had a visitors' area. Residents could not come and go from the facility as they wished as the front door was locked.

Residence facilities and maintenance

The residence comprised one single bedroom, two three-bed rooms, and one two-bed room; two sitting rooms; one dining room; a kitchen area; and staff toilet. There was an external laundry room with a washing machine and dryer. There were communal bathrooms and one en suite bathroom available to the residents. Each resident had an individual wardrobe and bedside locker. Twin and three-bed rooms had adequate provision for personal privacy, with privacy curtains in place between bed spaces. The interior of the building was not in a good state of repair. The upstairs communal bathrooms contained old, outdated fixtures and fittings with exposed pipework, a stained mirror, and crumbling paintwork. One of the downstairs sitting rooms was worn looking, with old and outdated wallpaper, damaged paintwork on the windowsills, discoloured skirting boards, and worn furniture. The bathroom windows did not have restrictors in place. The bedrooms were tired looking, and only one bedroom was personalised with pictures and paintings. The

remaining bedrooms were drab, with tired paintwork throughout and the floor covering was both old and stained. The house was not purpose-built and not in keeping with a 21st century mental health care facility.

The inspector met with the operations manager for CHO 2, who explained that there is currently an interim plan in place to move the existing Oak Grove residents, three to a nursing home and five to a nurse-supervised bungalow by October 2017. There is also a longer term plan to have two newly constructed, purpose-built bungalows to accommodate existing residents and future residents with an intellectual disability. The operations manager informed the inspector that funding has been secured for two new bungalows to be constructed, with the proposed completion date set for 2019.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager		
Registered Psychiatric Nurse/Intellectual Disability Nurse	1	1
Health Care Assistant	3	1
Multi-Task Attendant	0	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	1
Social Worker	1
Clinical Psychologist	1
Other	Awaiting recruitment of speech and language therapist.

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Weekly
Non-Consultant Hospital Doctor	0

There was no CNM2 working in Oak Grove; there was a CNM2 who has responsibility for the residence along with other community residences.

The health care assistants employed in Oak Grove had responsibility for cooking and domestic duties. No multi-task attendants were employed. This may be a concern moving forward as cooking and domestic duties are not inclusive to the role of a qualified health care assistant.

Complaints

The residence used the HSE complaints procedure *Your Service Your Say*. There was a notice concerning the complaints process in the entrance hall, which outlined the procedure. Minor complaints, when they arose, were addressed by the CNM2. There was a complaints log in the residence at the time of inspection, but no complaints were received or documented. Major complaints were escalated by the CNM2 to the assistant director of nursing and/or the complaints officer for CHO 2. No community meetings were held in the residence, and there was no suggestion or comments box.

Risk management and incidents

Oak Grove had a risk management policy, which was implemented throughout the residence. Risk assessments were completed for residents and documented in their clinical files. Incidents were documented and reported as per the HSE's National Incident Management System. The residence appeared to be physically safe, and fire extinguishers checked were in date. There was a first aid kit in the nurses' station and fire escapes were easily accessed. The assistant director of nursing monitored all incidents and, where necessary, identified any outstanding risks in the risk register.

Financial arrangements

The residence did not have a policy in relation to managing residents' finances. The weekly charge for residents was €70, which covered accommodation, food, and utilities. Residents held their own monies in the post office or in personal bank accounts. There was no communal social fund or charge.

Service user experience

The inspection team greeted residents and explained the purpose of the inspection. No service user expressed a desire to meet with the inspection team on an individual basis.

Areas of good practice

1. A supportive relationship between staff and residents was evident.

2. There was a nurse key worker system in place for each resident to provide continuity of care.

3. Medication Prescription and Administration Records currently in use within Oak Grove were of a high standard.

Areas for improvement

1. Refurbishment of the premises is essential, in particular the toilet and bathroom facilities and the bedrooms. If the plans to move the residents by winter 2017 and the longer term proposal to rehouse them in new, purpose-built care homes by 2019 are realised, issues relating to the premises will be resolved. The current premises are not purpose-built or suitable to meet the needs of residents over the short or long term.

2. There was a lack of therapeutic and recreational programmes for the residents, who either attended or did not attend the activation centre. Further steps should be taken to ensure that there are more occupational therapy and nursing programmes in relation to the provision of therapeutic and recreational programmes and services for residents in Oak Grove.

3. All community meetings providing a forum for complaints, comments, or suggestions by residents should be documented so that there is clear evidence that any issues arising are acted upon.

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