Riverview

ID Number: RES0037

24-Hour Residence – 2017 Inspection Report

River View
Ballinasloe
Co. Galway

Community Healthcare Organisation:
CHO 2

Team Responsible:
Rehabilitation

Total Number of Beds:
9

Total Number of Residents:
9

Inspection Team:
Barbara Morrissey, Lead Inspector

Inspection Date:
16 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

Riverview House was owned and managed by the Health Service Executive, (HSE) and was under the governance of Galway Region 5,(GR5) and the wider governance of Community Healthcare Organisation 2, (CHO2). The purpose of this house was to provide a rehabilitation and recovery service. Riverview House was a 9-bed, 24-hour nurse-staffed residence. It was located in an urban area on the east side of Ballinasloe town. The residence was within walking distance from the town centre and its amenities. The Creagh training centre was nearby and residents of the residence attend here. The name Riverview originated from the fact that a river runs at the back of the house. It was a large, two-storey detached house. Riverview was built in the 1930s as a doctor's house and opened as a 24-hour residence in 1995. The residents of Riverview were under the care and treatment of the rehabilitation team. Residents had access to general health services through Portiuncula University hospital in the town.

At the time of the inspection, there were nine residents in Riverview. Residents were accommodated in two single and three double rooms. The residence also provided outreach to 12 individuals, 11 of whom were living in flats nearby. The policy for admission to Riverview House was made available to the assistant inspector and it outlined that acutely ill clients, clients who following a risk assessment were deemed to be a risk to themselves or others, or clients from an intellectual disability service would not meet the criteria for admission to Riverview House. The Mission Statement reported that "*our aim is to facilitate recovery by working in partnership with service users focussing on individual strengths and needs, ensuring that dignity, respect and confidentiality are maintained at all times. We will accomplish this by providing a recovery focused mental health service comprising of various professionals guided by research and best practice working in collaboration with service users, families, carers and advocates*".

Resident profile

Residents ranged in age from their 40s to their 60s. At the time of inspection, there were three female and six male residents. These residents had been in Riverview House for a considerable period of time, from seven to eight years to more than ten years. Two residents were wards of court. All residents were fully mobile. No residents were on respite at the time of the inspection. Staff reported that there had been no respite admissions for over seven years.

Care and treatment

The newly appointed rehabilitation team consultant psychiatrist attended the residence weekly. Riverview had an up to date policy in relation to individual care planning, which was dated November 2016. All of the residents had an individual care plan (ICP), most of which had been developed in 2016. There was no set time frame for reviewing ICPs, but the consultant psychiatrist had reviewed all clinical files and was in the process of updating the ICPs. The ICPs were not developed by a multidisciplinary team but by the consultant psychiatrist and the keyworker. The rehabilitation team did not have access to a non-consultant hospital doctor (NCHD), or a social worker or a psychologist. There was no evidence in the ICPs inspected that the occupational therapist had attended the Multi-disciplinary team (MDT) meetings.

MDT meetings were held in the residence every six months. Residents were encouraged to attend these meetings. Staff had good knowledge of each resident's social and family supports. It was not indicated in the ICPs if the resident or a family member/carer attended these meetings. Residents had not signed the ICPs and it was not clear how much input the residents had into their ICPs. There was a key worker system in place. ICPs had needs, goals and interventions and resources outlined. Resources for interventions were indicated in the ICPs, they were not specific but listed as the MDT however this team did not have the required clinical disciplines to comprise an MDT.

Physical care

Riverview had a general health policy, dated November 2016. All residents had access to a GP and attended as the need arose. There were no set time frames for the completion of physical examinations. The clinical files inspected indicated that residents' GPs made referrals for appropriate national screening programmes and that residents were receiving appropriate screening. No information on National Screening was provided in the residence. The Simpson-Angus Neurologic Rating Scale was used to assess residents. Other health checks included an annual Electrocardiography, (ECG) and regular blood tests.

Residents had access to other health services, including speech and language therapy, in the out-patients' department at Portiuncula University Hospital. Residents were supported to attend specialist medical and clinical appointments. Clinical files were not in good order and it was difficult to locate physical assessments. There was an Automated External Defibrillator (AED) in the residence, and it was checked weekly. There was also a first aid box. Nursing staff did not have up to date training in Basic Life Support.

Therapeutic services and programmes

Riverview had a policy in relation to therapeutic programmes. Therapeutic programmes were not delivered in the residence. There was no evidence in the clinical files inspected, of input from the occupational therapist in assessing residents for therapeutic services and programmes to meet assessed needs. Residents attended the nearby Creagh Training Centre, which provided activities such as woodwork, computer skills,

cooking, guitar lessons, horticulture, environmental studies, flower arranging, arts and crafts, and health and fitness activities such as the walking club, indoor games, aerobics, exercise to music groups.

Residents attended the local leisure centre for swimming, aqua aerobic classes and gym facilities. Links with local further education centres was also facilitated. The Creagh Training Centre had links to local groups such as Ballinasloe book club, tidy towns committee, local soccer club, Ballinasloe training for employment, neighbourhood watch and Ballinasloe Men's Shed. Residents also attended programmes at a local day centre, Ard Mhuire, where groups such as healthy living, dance, mindfulness, and relaxation took place. If residents did not wish to attend the Creagh training centre or the local day centre, then no alternatives for therapeutic input was available within the residence. Nurses and multi-task attendants had all received training in recovery, including the incorporation of recovery processes into the activities of everyday life.

Medication

The residence had a policy on the ordering, prescribing, storing, and administration of medication, dated April 2017. Medication was prescribed by the consultant psychiatrist, as there was no non-consultant hospital doctor working with the MDT. A Medication Prescription Administration Record (MPAR) system was in operation. MPAR templates lasted six months, and were observed to be untidy and unclean and overall in poor condition. All MPARs contained valid prescriptions and administration details. A number of omissions were identified in two MPARs. The allergy section was not completed in four MPARs inspected and the initiation date for medication was not recorded in one MPAR. No resident in the residence was self-medicating. No medication related information was available in a user friendly format.

Medicines were supplied by a local pharmacy and appropriately and legally stored in the clinical cupboard. Each resident's medication was kept in a separate plastic box. However, personal property was also kept in the medication cabinet and this was not good practice.

Community engagement

The location of the residence facilitated community engagement. Residents had access to regular buses and trains to Galway city, and they attended the local Creagh training centre. Regular outings and day trips were organised, and residents went shopping, to the gym, and the hairdressers. They also could go to bingo in Athlone. The residence had a people carrier, which helped to support resident engagement in community activities. There was no community in-reach to the residence. Riverview was within walking distance from local churches. Information on mass times and multi-faith services was provided in the approved centre.

Autonomy

Resident accommodation consisted of single and shared bedrooms on the first floor of the residence. Storage space was provided within the bedrooms for personal property and possessions. Bedrooms were warm comfortable and homely. A number of residents had personalised their bedrooms. All meals were cooked by a multi task attendant. The meals provided reflected the resident's preferences and were prepared from fresh ingredients and provided a wholesome balanced diet. There was no baking or cooking group run in the facility.

Residents had access to the kitchen area within the residence, but the kitchen was locked at certain times of the day, however, residents could request the keys and use the facilities. This was not in line with recovery principles. Residents were not involved in the food shopping for the residence. Residents did not have keys to their own bedrooms because some rooms were shared. Residents were free to determine their own bedtimes. Residents helped with household tasks. Visitors were welcome in the residence at any time. Residents could come and go from the facility as they wished.

Residence facilities and maintenance

The gate at the main entrance was rusty and had not been attended to. The garden at the back of the house was well maintained and consisted of a lawn, shrubbery and trees. The residence had two single bedrooms and three double rooms. In two of the double rooms, there was no curtain between the beds, which was not conducive to resident privacy. The floor covering in the upstairs bathroom was in poor shape and needed replacing. The painting on the dining room and the sitting room walls, had large cracks in it.

There was a homely dining room, and meal times were displayed. Meals and snacks were served at regular intervals. A water dispenser was available in the kitchen. There was a comfortable sitting room, with newly upholstered furniture. There was an electric stove in the sitting room. Contract cleaners cleaned the windows. The nursing office was also the clinical room. Most information for residents such as mass times, bus times, and the complaints policy was displayed on a notice board in the office. This office/clinical room was observed to be untidy and unorganised. Residents had no privacy when receiving medication, as it was administered in the nursing office. The premises was not wheelchair accessible.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager 2	0	1 cnm2 OR 1 RPN on night duty.
Registered Psychiatric Nurse	2	0
Health Care Assistant	0	0
Multi-Task Attendant	2	1

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	0
Clinical Psychologist	0
Other (specify)	0

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

Complaints

The residence had a complaints policy, and it used the HSE complaints procedure “Your Service Your Say”. Residents were aware of how to make a complaint, and there was a nominated person for complaints. Community meetings were held weekly in the residence and this was a forum for making complaints, and minutes of these were maintained. Residents had access to a suggestion box.

There was a sign in the nursing office, detailing the contact details for the Irish Advocacy Network. No complaints log was available. The CNM2 addressed and dealt with complaints at a local level and all complaints that could not be resolved locally would be escalated to the nominated complaints officer for the residence. Staff on duty reported that there were no outstanding complaints associated with the approved centre at the time of the inspection.

Risk management and incidents

Riverview House had a risk management policy, but it was a service policy and not specific to the residence. There was an emergency plan in relation to the Ballinasloe horse fair, which is the largest horse fair in Ireland and takes place yearly in the town. Residents were risk-assessed in January 2017 using the Functional Analysis of Care Environments (FACE) risk profile tool. Residents were also risk-assessed for falls in February 2017. Incidents were documented and reported by nursing management. The fire escape door on the first floor opened out onto a flat roof and residents were not risk assessed in relation to this. The smoking shed at the front of the house had flammable items inside.

Fire extinguishers were checked and in date, and fire escapes were easily accessible. However, the fire exit on the first floor led out onto the roof, which was a safety concern. Staff had access to an automated external defibrillator, and a first aid kit. The assistant director of nursing monitored all incidents in the residence.

Financial arrangements

The residence had a National Health Service Executive policy, titled Financial Management in Community Residences, 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 a communal social fund, which was used to pay for the Christmas party, outings, or whatever residents decided at their regular community meetings. There was no signed consent to contribute to this fund but staff reported that there was a verbal agreement in place and this was reviewed regularly. Residents' finances were audited regularly by the HSE in Merlin Park, Galway.

Service user experience

The assistant inspector greeted residents and explained the purpose of the inspection. Residents were hesitant about speaking with the assistant inspector and therefore it was difficult to obtain feedback on the service provided.

Areas of good practice

1. Staff are trained in Recovery.
2. The updating of all Individual Care Plans.
3. Regular Recreational Outings.
4. Wholesome nutritious food is provided.

Areas for improvement

1. The shed to the front of the house had flammable substances and residents were smoking in this area.
2. No privacy curtains in two shared bedrooms.
3. Painting in the sitting room and the dining room was in poor condition.
4. Clinical files and Medication Prescription Administration records, (MPARS) were in poor order.
5. There was no Multidisciplinary input in to the ICPs and meeting the assessed needs of the residents.
6. Gate at the front entrance was rusty and in need of attention.
7. Not all staff had received up to date training in basic life support.
8. Residents need to be risk assessed in relation to the first floor fire exit door that has access to a flat roof.
9. A complaints log should be maintained so that there is clear documentation of any complaints arising and the response to resolve the matter.