St. Mary's

ID Number: RES0096

24-Hour Residence – 2017 Inspection Report

St. Mary's Residence
St. Mary's Hospital
Dublin Road
Drogheda
Co. Louth

Community Healthcare Organisation:
CHO 8

Team Responsible:
Rehabilitation

Total Number of Beds:
9

Total Number of Residents:
8

Inspection Team:
Mary Connellan, Lead Inspector
Marianne Griffiths

Inspection Date:
09 June 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

St. Mary's residence was located in the grounds of St. Mary's Hospital on the Dublin Road in Drogheda. The premises, which was owned by the HSE, was a former convent and was over 100 years old. An extension had been built adjacent to the original building. The residence opened in 1991, initially as medium support house. It had been operating as 24-hour supervised residence since 1999.

The residents were all under the care of the rehabilitation team. Residents had been transferred from their respective sector teams earlier in the week of the inspection. This had been a planned and phased transfer of care for each. Three sector teams had been providing care for these residents. The inspection team was informed that the registered proprietor and business manager had also visited the residence earlier in the week of the inspection because the needs of the residents and the future plans for the residence were under discussion. There were seven residents and two respite beds in the community residence. On the day of the inspection, there was one respite vacancy. With the exception of the resident who was on respite, the length of stay in the residence ranged from two years to long stay

Care and treatment

There was no policy on individual care planning. On the day of the inspection, all residents had an active nursing care plan. The plans were updated in conjunction with residents on a three-monthly basis or more often if required. Weekly sector team meetings were held in the sector headquarters and residents' care was reviewed at least on a six-monthly basis. The clinical nurse manger had attended these meetings up until one month prior to the inspection. A new process was being introduced at the time of the inspection. A nurse key working system was in operation.

A multi-disciplinary care plan had been developed for each resident by the rehabilitation team in conjunction with the resident and the sector team from which they were transitioning. Each individual care plan included a Camberwell Assessment of Need, a mental state examination, a physical examination, and full blood screening. A comprehensive case summary had been completed for each resident. These assessments and care plans were developed in the weeks preceding the inspection and were being introduced on the day of the inspection.

Physical care

There was no policy on general health care. All residents had access to their own GP and appointments were made at least six-monthly. Information was provided about national screening programmes, and residents had received appropriate screening. A chiropodist attended the residence every three months and residents attended the practice outside of these times, if desired. There was evidence of both speech and language and physiotherapy input, as required by residents.

Therapeutic services and programmes

There was no policy on therapeutic programmes. Therapeutic programmes were not delivered in the residence. Residents attended St. Brigid's Day Centre twice weekly. This centre provided structured group activities, including art, relaxation, and a Wellness Recovery Action Plan group. Staff reported that they facilitated recreational activities in the residence throughout the week.

Medication

There was a policy on medication management. Medication had been prescribed either by the general practitioner or the registered medical practitioner from the respective sector team. All of the Medication Prescription Administration Records contained a valid prescription and administration details for medication. Two residents were self-medicating. Medication was stored appropriately in individual compartments in a locked cabinet. Medication was supplied by a local named pharmacy.

Community engagement

St. Mary's residence was located on the outskirts of Drogheda and was accessible to local amenities, including a church and library. Some of the residents were involved with local groups and were facilitated to do so by staff who drove the resident if desired. Residents regularly visited a local shopping centre and coffee shop.

Autonomy

Residents did not have access to the kitchen. Staff reported that this was due to health and safety and environmental health requirements. Meals were prepared in and delivered from three different sources throughout the week. These included a local supermarket, St. Brigid's Hospital in Ardee, and the Care of the Elderly facility located opposite the residence. All residents had their own key to the front door, but

individual bedroom doors did not have locks. Residents were free to leave the residence as they wished and were asked to inform staff of their movements for the fire safety protocol. Visitors were welcome to the residence at any time.

Residence facilities and maintenance

The two-storey residence had a well-maintained and generously sized garden located at the rear. There was a separate utility/laundry room that housed the washing machine and dryer.

There was a small nursing office located in the entrance hall. The entrance area was noted to be dusty and generally not well maintained or properly cleaned. The kitchen, which was not accessible to the residents, was old and needed a deep clean. Cooked food was not prepared here. The utility/laundry room could be accessed through the kitchen but not by the residents, who had to go out of the front door to get into the laundry room. There was a sitting room and dining room that had recently been painted and a downstairs bathroom. Sleeping accommodation was in single bedrooms, four of which were located downstairs in the newer extension area of the building; the rest were upstairs. A bathroom downstairs had been upgraded, and there was an easy-access shower room. One toilet near the sitting room and dining room was noted to be clean, but the inspection team noted that the residence was malodourous. Bedrooms were not en suite. There was a bathroom with a bath upstairs and a separate shower room with a toilet that needed upgrading.

Externally, the older original building was in need of general repair. The paint on the windows and doors was noticeably chipped. It was evident that there had been some redecoration and upgrade of the facilities. A member of the maintenance staff from St. Brigid's attended the residence weekly. However, there did not appear to be a systematic upgrade and maintenance programme. Small repair jobs were completed in a timely fashion, but the residence was in need of a deep clean as well as further refurbishment and upgrading.

The inspection team acknowledged that representatives from the management team had completed a walkabout in the residence very recently.

Staffing

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	As required
Clinical Psychologist	

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

Up to the time of the inspection, the consultant psychiatrist and non-consultant hospital doctor did not routinely attend the residence. This was under review, and staff reported that the rehabilitation team would be available in the residence going forward.

Complaints

There was a complaints policy and an identified person responsible for addressing complaints. The management adopted the HSE's *Your Service, Your Say* complaints policy, and residents were aware of how to make complaints. A complaints log had not been maintained in the residence. Community meetings were held monthly and identified actions that were followed up by staff. However, there was a gap in the documenting of recent meetings.

Risk management and incidents

There was a policy on risk management, which had been implemented throughout the residence. Audit and risk assessments, including resident risk assessments, were completed. The National Incident Management System was used for reporting incidents. Fire extinguishers were checked and were in date. A carbon monoxide alarm was evident. There was a fire escape from the second floor to the grounds of the hospital campus. There was a first aid kit and an Automated Electrical Defibrillator (AED), which were checked weekly. The residence was monitored by an alarm system and staff also carried a personal panic alarm in line with the policy on lone working.

Financial arrangements

There was no policy on resident finances. There was a property and possessions policy dated April 2009. It did not reflect the financial arrangements for the residents in the residence. The staff information folder included details of the protocols and practices for the management of resident finances. There was a fixed charge payable to St. Brigid's Hospital by each of the residents. Residents had either a bank or post office account and were supported by staff to manage their own monies.

Service user experience

The inspectors met with six of the residents who had gathered for their main meal. The residents were complimentary about the care they received in St. Mary's and praised the food. No issues were raised with the inspectors and none of the residents opted to meet individually with the inspectors.

Areas of good practice

1. The commencement of a rehabilitation consultant and care team for all the residents.
2. The introduction of a multi-disciplinary individual care plan for each of the residents.
3. The provision of a respite service to identified residents living in the community
4. The involvement of the assertive outreach team with identified residents who were availing of respite care in the residence.

Areas for improvement

1. The general cleanliness of the residence should be addressed, including a deep clean of the kitchen and entrance hallway.
2. General maintenance and upkeep of the external parameter of the building is required, including repainting.
3. Residents should have more direct access to the laundry facility.