Havenview

ID Number: RES0075

24-Hour Residence – 2018 Inspection Report

Havenview
Enniscorthy
Co. Wexford

Community Healthcare Organisation:
CHO 5

Team Responsible:
Rehabilitation

Total Number of Beds:
14

Total Number of Residents:
13

Inspection Team:
Dr Ann Marie Murray, MCRN363031, Lead Inspector

Inspection Date:
31 January 2018

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

Havenview was a 14-bed, 24-hour, nurse-staffed residence in Enniscorthy, Co. Wexford. The purpose-built bungalow was owned and operated by the HSE. It opened as a 24-hour residence in 2014. At the time of inspection, Havenview was accommodating 13 residents, all of whom had a primary diagnosis of intellectual disability, from mild to severe. The residents' care and treatment was provided by registered psychiatric nurses and a rehabilitation psychiatry multi-disciplinary team, despite the residents' primary needs being related to their intellectual disability.

Residence facilities and maintenance

Havenview was a H-shaped, modern building. It contained 14 single bedrooms with en suite bathroom facilities, a sitting room with a TV and comfortable furnishings, a bathroom, a kitchen, a dining room with a large communal table and seating for seven residents, and a quiet room. There was also a laundry/linen room, a store, and what appeared to be a seclusion room, which staff said was not in use.

The centre was divided into a high dependency area and a lower dependency area. There were attractive paintings on the walls of the corridors. The outside of the house was well maintained. There was an outdoor smoking area as well as attractive seating areas with benches and shrubs. Externally, the windows had not been cleaned regularly. There was no programme of routine maintenance for the residence. Maintenance issues were handled centrally in St. Senan's Hospital in Enniscorthy as they arose.

One of the residents' bedrooms was sparsely furnished with no items other than a torn mattress on the floor and an unused TV behind a screen. Residents had TVs in their bedrooms, which were encased in wooden boxes with a Perspex type screen covering the TV. Staff reported this was done due to the risks of residents breaking the TVs. Staff acknowledged that not all residents would be at risk of smashing TVs yet they were covered in all residents bedrooms. There was no review of the rationale for these TV protectors, other electronic items such as DVD players were observed in residents' rooms without protectors.

Large piles of residents' clothes were observed left on the floor in the laundry room, this was not in line with infection control standards. One of the dryers had broken in the laundry recently and a new one had been ordered. At the time of the inspection, worn linoleum was being replaced throughout the residence. A new suite of furniture, standing hoists, and new wheelchair accessible minibus had been purchased for the service.

Resident profile

At the time of the inspection, Havenview was providing accommodation for 13 male residents. They were aged between 42 and 70. Most of the residents had been transferred from St. Senan's Hospital when it closed, and had been in the residence since it opened. The most recent admission was in 2017. All of the residents had a primary diagnosis of an intellectual disability; however, residents did not have access to an intellectual disability mental health team. Some residents had a secondary diagnosis of mental illness, and a number had physical disabilities and were wheelchair users. Appropriate accommodation was available for residents with physical disabilities, including wheelchair accessible bedrooms and bathrooms.

Care and treatment

Havenview had a policy in relation to individual care planning, which was a Waterford/Wexford service policy and was stored electronically. All of the residents had an individual care plan (ICP). The ICPs were typed and clear to read. The ICPs were not drawn up by a full multi-disciplinary team as there was no evidence of input from a psychologist and the occupational therapist and social worker did not always attend ICP review meetings. Residents attended ICP reviews, which occurred every three to six months or as required in the residence. Nurses in the residence functioned as key workers. The key worker was not always a consistent named individual. A review of six clinical files indicated that residents received a psychiatric evaluation at least six-monthly.

Physical care

Havenview used the Waterford/Wexford Mental Health Services policy in relation to physical care and general health. All residents had access to a local GP. Physical examinations were completed every six months by the non-consultant hospital doctor using a form. The form used during the completion of a physical examination was very dated and in need of review.

Information on national screening programmes was not provided routinely. Residents were receiving appropriate screening, but this was not being systematically monitored. Residents had access to dentistry and optical treatment, but only when symptoms arose. Residents did not receive regular routine dental or optician reviews. They could access speech and language therapy in Wexford, a dietitian in the local community clinic, physiotherapy in the community, and hospital services in Wexford.

Therapeutic services and programmes

Havenview used the Waterford/Wexford Mental Health Services policy in relation to therapeutic programmes. The occupational therapist had completed a Global Needs Assessment on all the residents. Needs had been identified by the occupational therapist in relation to therapeutic activities for residents but these had not been fully implemented due to limited resources. Many of the residents presented with challenging behaviours in the context of intellectual disability; however, none of them had positive behavioural support plans in place that were being implemented. Residents did not have access to communication assessments from a speech and language therapist. None of the staff were trained in Lamh, a manual sign language system used by children and adults with intellectual disability and communication needs in Ireland, despite some residents having significant communication difficulties. Staff reported that one resident used a Picture Exchange Communication System (PECS) to augment communication; however, when the inspector went to review this, it was not in place. It was not evident that staff had been trained in how to use PECS.

A horticulturalist attended the residence regularly to run a horticulture group, and a musician delivered music sessions on-site. These activities were facilitated by the occupational therapist. One resident attended the Killagoley Training & Activation Centre (KTAC) in St. Senan's where they accessed games, gardening, and recreational activities. This was run by mental health services and was not a specialist intellectual disability service. A request had been placed for residents to access iPads as "Assistive Technology". "Assistive technology" is the use of technology that can enable people with disabilities to maximise their independence. Staff had completed training in this.

Recreational activities

Residents in Havenview had access to a variety of recreational activities. These included foosball, pool, walking, football, shopping trips, and daily minibus outings. There was also a weekly swimming group and a sports group, run by the occupational therapist and occupational therapy assistant.

Medication

The residence used the Waterford/Wexford Mental Health Services policy in relation to medication management. Medication was prescribed by the consultant psychiatrist, GP, or non-consultant hospital doctor. A Medication and Prescription Administration Record (MPAR) system was in use, and residents' MPARs contained valid prescriptions and administration details. At the time of inspection, none of the residents were self-medicating.

It was evident that a resident had been prescribed medication for the purpose of chemical restraint. This had not been adequately identified and documented as such, and was not subject to systematic monitoring. There was no positive behavioural support plan in place for this resident.

Medication was supplied from Wexford General Hospital, on an individualised basis. An individual drawer was allocated to each resident for storing medication. Expired medication was observed in the cupboard during the inspection, and the medication fridge was in need of cleaning. There were gaps in the documentation of monitoring fridge temperatures. There was no systematic review of the medication inventory or of expiry dates of medication.

Community engagement

Although Havenview was located close to the centre of Enniscorthy, residents did not engage much in community activities. Some residents who were more independent attended football matches and could travel by bus to Wexford or Dublin. The residence had access to a shared seven-seater, wheelchair-accessible minivan, which was used to bring residents to activities and appointments. There was very little in-reach into the residence from the community, apart from at Christmas.

Autonomy

Residents did not have full and free access to the kitchen because of health and safety concerns. Residents were free to determine their bedtimes, but none of them had a key to their own bedrooms. This had never been considered or reviewed. Residents' wardrobes were locked; staff reported this was due to the risk of other residents taking their property. There was no review or monitoring of this practice. Some of the residents helped with household chores, including shopping, tidying their rooms, and putting laundry away. Residents could come and go as they wished but generally did not. They could receive visitors at any time.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager 2	1	0
Registered Psychiatric Nurse	2	2
Multi-Task Attendant	2.5	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	As required
Clinical Psychologist	None

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Weekly and as required
Non-Consultant Hospital Doctor	Weekly and as required

Staff had received up-to-date training in Basic Life Support, fire safety, and the management of aggression and violence. The unit was staffed by all male staff due to the risk of aggression and violence. Nursing staff reported they did not have specific training in caring for residents with intellectual disabilities.

Complaints

Havenview had a complaints policy and used the HSE's *Your Service, Your Say* complaints procedure. It was not apparent that residents were made aware of how to make complaints. The signage in relation to the *Your Service, Your Say* process was not appropriate to the residents' communication levels.

Staff reported complaints were generally received in verbal form and, where possible, were addressed on the spot. All staff were responsible for dealing with complaints. Where a complaint needed escalation, it was progressed to the assistant director of nursing, who was the nominated complaints officer. At the time of inspection, a complaints log had been recently introduced, but it did not contain any complaints.

Community meetings were not held in the residence, and there was no suggestion box on the premises.

Risk management and incidents

The residence used the Waterford/Wexford Mental Health Services policy in relation to risk management, but it was not being fully implemented in the house. There were outdated hazard identification forms, which did not include risk ratings. Two of these were sent in after the inspection with the risk rating now included; however, the forms failed to document the risk owner or the due date.

Residents were assessed for risk of falls, and the Sainsbury and Waterlow clinical risk assessment tools were in use. The Sainsbury assessment did not include a risk management plan. There was evidence of risk management as part of the multi-disciplinary team meetings. Incidents were reported and documented using the National Incident Management System, but there was no system in place for reviewing trends.

There was no evidence to suggest the resident was not physically safe. Fire extinguishers were serviced and in date. A large piece of foam was evident in one of the fire exits; this was highlighted to staff to remove it. There was a first aid kit in the clinical room. Fire drills did not occur. There was no evacuation plan or personal evacuation plan for residents.

Financial arrangements

Havenview had a local operational policy that addressed the management of residents' finances. All residents paid a weekly charge, which covered food and utilities. Residents' finances were managed centrally by administrative staff in St. Senan's Hospital, and residents accessed their money through staff. Appropriate procedures were in place in relation to staff handling residents' money.

Residents did not contribute to a kitty or social fund. Residents' finances were audited on a six-monthly basis.

Service user experience

The assistant inspector met with residents throughout the inspection. Those who were non-verbal appeared content. All residents wore clean clothes that respected their dignity. None of the residents who spoke to the assistant inspector had any comments on their care and treatment or of the residence itself.

Areas of good practice

1. Individual care plans were typed and clear to read.
2. The service had requested iPads and had trained some staff in "Assistive Technology".
3. Medication storage in individual drawers made it easier to identify residents' medication.
4. It was evident that nursing staff were attempting to engage residents in activities.

5. A new suite of furniture, standing hoists, and new wheelchair accessible minibus had been purchased for the service.

Areas for improvement

1. As residents' primary needs related to their intellectual disability, it was not appropriate that the mental health service provide care and treatment to this population of residents. The residents should be more appropriately cared for by social care/disability model of care.

2. Residents did not have access to intellectual disability activation services, speech and language therapist to assess communication, and a behavioural specialist or a psychologist.

3. Community meetings were not held in the residence, and there was no suggestion box on the premises. The service should encourage community meetings or consultation with families if residents unable to engage.

4. There was no review or oversight of restrictive practices, which were many.

5. The use of chemical restraint should be reviewed by the consultant psychiatrist.

6. There were areas for improvement in relation to risk management:

    (a) A large piece of foam was evident in one of the fire exits; this was highlighted to staff to remove it.
    (b) Fire drills did not occur.
    (c) There was no evacuation plan or personal evacuation plan for residents.
    (d) The service may consider reviewing trends of incidents to identify areas for improvement.

7. There were areas for improvement in relation to the premises:

    (a) The service should review the purpose and use of the seclusion type room.
    (b) One resident's bedroom was sparsely furnished and was in particular need of attention.
    (c) Infection control guidelines should be followed in relation to linen and handling of resident clothes.
    (d) The windows should be cleaned.

8. There were areas for improvement in relation to physical health care:

    (a) The form used for physical examination was outdated and in need of review.
    (b) The service may consider monitoring residents' uptake of national screening programmes.
    (c) The service should facilitate regular dental, optical reviews where possible and appropriate.

9. Expired medication was observed in the cupboard during the inspection, and the medication fridge was in need of cleaning. There were gaps in the documentation of monitoring fridge temperatures.