Maple Lodge

ID Number: RES0045

24-Hour Residence – 2018 Inspection Report

Maple Lodge
Kilconnell Road
Ballinasloe
Co. Galway

Community Healthcare Organisation:
CHO 2

Team Responsible:
Mental Health Intellectual Disability

Total Number of Beds:
5

Total Number of Residents:
4

Inspection Team:
Mary Connellan, Lead Inspector

Inspection Date:
24 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

Maple Lodge, a five-bed, 24-hour, staffed residence, was located in the town of Ballinasloe, approximately 1km from the main centre. It was positioned on a busy road amongst residential housing. The bungalow was owned by the HSE. It had opened as a community residence in 2004. At the time of inspection, Maple Lodge was providing continuing care for four residents with intellectual disabilities. The future plan for the residence was for it to remain as was.

Residence facilities and maintenance

Maple Lodge accommodated residents in four single bedrooms. There was a fifth bedroom that was not in use. There was one shared toilet and shower facility for the residents and a separate toilet for staff. The resident bathroom and bedrooms were small and in need of modernisation and updating. Staff reported that the interior of the wardrobes had been dry lined as a result of rising damp. The lower section of the bedroom walls and bedroom corridor had been tiled. This was also reported as a measure to conceal rising damp. The bedroom corridor was narrow and there was a tile missing around a wall plug, which was unsightly.

The communal area of the residence comprised a kitchen cum dining room with an adjoining conservatory. There was a utility room with a clothes dryer. The washing machine was kept in a shed in the back garden. A staff office that contained a locked medicine trolley had a couch and seating. This room was accessible to the residents.

The back garden was spacious and, while well maintained, it was sparse. The exterior of the residence had been painted within the previous year, as had the garden furniture.

Resident profile

At the time of inspection, Maple Lodge was accommodating three female and one male resident. The occupants were aged between 57 and 74, and the duration of stay ranged from 1 ½ to 14 years. Appropriate accommodation was available for the residents with a physical disability. A walking aide and tripod were used by two residents, respectively. The residence would not be suitable for any resident requiring a wheelchair.

Care and treatment

Maple Lodge had a policy on individual care planning. All residents had an individual care plan (ICP), but these did not have full input from the multi-disciplinary team. All of the ICPs had been developed by the care staff; however, the clinical files contained evidence of input from allied health professionals.

Residents had full input into their ICPs and worked closely with their respective key worker. The individual ICP reviews took place at least six monthly, held in an associated day centre, and the residents attended with care staff from the residence. A six-monthly psychiatric evaluation was not documented for each resident. There was documented evidence that each resident had been seen by the consultant psychiatrist at least six-monthly.

Each resident had been assessed in relation to person-centred care and in terms of improving their outcomes. This assessment had been completed by representatives from the American Association on Intellectual and Developmental Disabilities (AAIDD). The outcomes were not evident in the respective clinical files and the inspector was informed that they were with the business manager.

Physical care

There was policy in relation to physical care/general health. All residents had access to and attended GP practices in the locality. Records inspected indicated that routine six-monthly physical examinations took place. The inspector was informed that these were documented in the individual files held in the GP surgery. Residents had access to and were participating in appropriate national health screening programmes as evidenced in the clinical files.

Residents had access to other health services such as physiotherapy, dentistry, and general hospital services. A speech and language therapist had commenced employment in the wider mental health service on the week of the inspection.

Therapeutic services and programmes

There was no policy available in relation to therapeutic programmes. Therapeutic programmes were generally not delivered in the residence. The residents attended a day centre affiliated with the wider service. As required and in line with care needs, residents had access to occupational therapy and psychology.

Recreational activities

Residents in Maple Lodge had access to a wide range of recreational activities and the care staff placed notable emphasis on pursing activities that the residents enjoyed. These included art, TV, walks, shopping, and outings to the library, coffee shops, and restaurants. Residents attended regular concerts, the hairdressers and beautician, and mass as they wished. One resident was attending a computer skills course following an expression of interest by this resident. Residents were also accompanied to their home places where possible.

Medication

Maple Lodge had a policy on medication management. Medication was prescribed by the residents' GPs and the consultant psychiatrist. A Medication Prescription Administration Record (MPAR) system was in operation, and each resident had an MPAR. These contained comprehensive prescription and medication administration details. Medication was administered by nursing staff who attended the house as required. Care staff had been trained in Safe Administration of Medication. While residents' medication was received in blister packs, care staff had not yet commenced administering it. This was being introduced in the wider service at the time of inspection. No residents were self-medicating.

Medications were supplied by a local pharmacy. Medication was stored appropriately in a locked cabinet. All regular medications were dispensed in blister packs.

Community engagement

The location of Maple Lodge, on the outskirts of a large town, facilitated community engagement. The residence had its own minibus. Staff drove any resident to the town and to any activity, unless accompanied by a family member or friend. The residence was located on a busy road.

Residents attended a wide variety of community activities.

Autonomy

Residents had access to the kitchen to prepare snacks or make tea or coffee, as desired. They were free to determine their own bedtimes, but no resident had a key to their bedrooms. Residents did have a key of the front door, although they would usually be accompanied by staff when returning to the residence. The bedrooms were personalised and two residents had their own TVs in their room.

While residents were free to leave the residence as they wished, the road safety issue meant they would always be accompanied. They were free to receive visitors at any time.

Staffing

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	No
Clinical Psychologist	As required
Speech and Language Therapist	As required

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

*A clinical nurse manager had responsibility for the residence along with other areas of responsibility. That staff member or staff nurses visited the residence twice daily and once at night to administer medication and was on call at all other times.

**The consultant psychiatrist attended the day centre weekly and met with the residents at least six-monthly in that location.

Complaints

Maple Lodge had a complaints policy, and all residents were aware of how to make a complaint. Details of the complaints officer were displayed on a noticeboard. Minor complaints were dealt with by the care staff on duty and a complaints log was maintained. Weekly community meetings were held, minutes of which were available. Residents could volunteer suggestions during these meetings.

Risk management and incidents

There was an up-to-date risk management policy, which had been implemented in the residence. Risk assessments were recorded in residents' clinical files. Incidents were documented and reported using an Incident Report Book. Incidents were also discussed at a service-wide meeting held each Monday.

The residence appeared to be physically safe, and the fire exits were easily accessible. Fire extinguishers were regularly serviced and in date. A fire drill was held weekly in the residence. There was a first aid kit on the premises.

Financial arrangements

Maple Lodge used the HSE's *National Financial Regulation in Community Residences* as their policy on managing residents' finances. A copy was available in the residence policy folder. The charge for residents for food was based on means, and a set amount per month for rent. The residents also paid for the oil fill and waste disposal collection.

Residents all had individual bank or post office accounts, and they had access to secure facilities within the residence for keeping their money. Appropriate procedures were in place for staff handling resident money, with the resident and one member of the care staff signing for any transactions. Resident finances had been audited monthly.

Service user experience

The inspector chatted informally with two residents who were in the house. Normally, all of the residents would have been at the day centre. These residents were content and appeared to be very well cared for.

A review of the clinical files indicated that each resident had a communication passport along with their ICP. There was a detailed account of each residents' likes and dislikes and a comprehensive assessment of need. It was evident from these files that staff knew the residents very well and it appeared that they were particularly committed to providing the best care for the residents.

Areas of good practice

1. Each resident had an identified key worker and associate key worker. Care staff knew the residents very well and made considerable efforts to meet their needs with a notable emphasis on resident likes and desires.

2. The care staff had recently completed training in Safe Administration of Medication. At the time of inspection, all regular medication was being dispensed in blister packs in preparation for the transition to care staff administering medication to the residents.

3. Each resident had recently been assessed by the American Association of Disability. While the individual assessments were not available at the time of inspection, it was reported that the service has undertaken a service-wide review and the outcomes were for discussion within the area management team.

Areas for improvement

1. The internal rooms need renovation, refurbishment, and upgrading. In particular, the inspector was informed that the residence had rising damp.

2. The individual bedrooms were small and did not have en suite bathroom facilities. There was one main bathroom for the residents. While it accommodated their needs at the time of inspection, it was recognised that this resident cohort is aging and requires more physical care needs. The main bathroom should be upgraded and, where possible, en suite facilities should be provided.

3. The back garden was well maintained but sparse and would be enhanced by a shrubbery and flower beds.