Maryfield Cottage

ID Number: RES0116

Low Support Residence – 2018 Inspection Report

Maryfield Cottage
Lissenhall
Swords
Co. Dublin

Community Healthcare Organisation:
CHO 9

Team Responsible:
Mental Health Intellectual Disability

Total Number of Beds:
4

Total Number of Residents:
4

Inspection Team:
Siobhán Dinan, Lead Inspector

Inspection Date:
17 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

Maryfield Cottage is a four-bed detached bungalow located in Swords Co. Dublin. It had been operating as a low-support community residence staffed by health care attendants only since 1990. The building was owned by the HSE. Maryfield Cottage provided accommodation for four residents under the care of the Mental Health Intellectual Disability team. There were four single bedrooms in total. The residence provides continuing care to residents with mild to moderate intellectual disabilities who are former in-patients of St. Ita's Hospital, Portrane. The philosophy of care in Maryfield Cottage was to foster and nurture residents' desire to live independently. Staff aimed to deliver care in a way that respects the uniqueness, individuality, and dignity of each resident in a holistic and person-centred manner.

Residence facilities and maintenance

Maryfield Cottage was poorly maintained and neglected in appearance. The garden at the front was overgrown, and the windows were observed to be dirty. All residents had their own bedrooms, and all rooms were personalised. However, some appeared bare and all bedrooms smelled musty. Bedrooms had single beds, wardrobes, drawers, and dressers. The residence also included a small sitting room with a large TV, a kitchen, a dining area, an office, a very small laundry room, and two shared bathrooms each with a shower. The paintwork in the kitchen, dining room, living room, and bathrooms was in poor condition. The small sitting room was comfortable but somewhat dated in appearance. Some furniture was tattered. The floor in one of the bathrooms was damaged and needed to be renovated or replaced. Staff reported that the clothes dryer in the dining room had an issue with venting and caused malodour when in use. There was a general air of neglect externally and internally in this residence, which had not been properly maintained for many years. Repeated requests for maintenance had not been addressed. Maryfield Cottage was in need of painting and redecoration.

Resident profile

Residents ranged in age from 51 to 74 years. At the time of inspection, two female and two male residents were accommodated in the residence and the duration of stay ranged from 8 to 13 years. All residents had a dual diagnosis of intellectual disability and mental illness. No resident had ward of court status. All residents were mobile.

Care and treatment

Maryfield Cottage had a policy with regard to individual care plans (ICPs), which was dated January 2014. The consultant psychiatrist attended the residence by request only and the non-consultant hospital doctor was available to residents fortnightly in a nearby clinic. All residents had an ICP. Care plans were reviewed every three to six months. Residents were involved in the care planning process and could attend their care plan review meeting. Residents signed their ICPs. There was no documented evidence that residents were offered copies of their ICP. None of the ICPs showed evidence of multi-disciplinary team (MDT) input. The ICPs evidenced medical and nursing input only. The clinical files contained no evidence of psychology, social work, or occupational therapy input. The MDT meetings were held weekly offsite and residents could attend. The clinical nurse manager 2 (CNM2) attended the MDT meetings. The clinical progress notes were well maintained and up to date and provided a clear account of each resident's progress, care, and treatment. A mental state examination was documented in the each file at least six-monthly. Health care attendants on-site functioned as key workers for the residents. Each resident had a key worker assigned to them.

Physical care

Maryfield Cottage did not have a policy in relation to physical care/general health. All residents had their own GP. Staff made appointments for residents to attend their GP and accompanied residents on GP visits if required. Physical examinations were undertaken by residents' GPs every six months or more frequently if needed and these were recorded in the clinical files. Information about national screening programmes was unavailable in the residence; however, residents did have access to appropriate screening programmes. Other health care services were available to residents, including physiotherapy, dentistry, chiropody, dietetics, and speech and language therapy. The GP or a member of one of the admitting teams made referrals where necessary.

Therapeutic services and programmes

Maryfield Cottage did not have a policy in relation to the provision of therapeutic programmes. Residents did not have access to therapeutic programmes within the residence. Three residents attended the EVE Estuary Centre on-site and one resident attended the Knockamann Resource Centre in Portrane, daily. The EVE Estuary Centre runs a foundation skills training programme, which was designed to equip participants with basic personal, social, and work-related skills. The course content included horticulture, interpersonal communication skills, visual and performing arts, personal hygiene and grooming, computer skills, sports, literacy and numeracy, independent living skills, and personal development. The Knockamann Resource Centre provided social, vocational, educational, and leisure activities for residents. The resource centre had a café, gymnasium, and multi-sensory rooms and a wide range of therapeutic services were available.

Recreational activities

Recreational activities available in the residence included board games, TV, and music. There were organised outings on weekends, which included trips to the local shopping centre, various shows, to cafés, and to restaurants. Recreational resources were also available in the EVE Estuary Centre and in the Knockamann Resource Centre. These included but were not limited to pool, gym, arts and crafts, gardening, knitting, dancing, music, baking, beauty care, woodwork, and swimming.

Medication

Maryfield Cottage had a policy in relation to medication management, which was dated June 2015. Medication was prescribed by the residents' consultant psychiatrist, a non-consultant hospital doctor, or their own GP. A Medication Prescription Administration Record (MPAR) system was in operation, and resident MPARs contained valid prescriptions and administration details. All residents were self-medicating and this was managed accordingly. Medicines were supplied a local pharmacy. Medications were stored appropriately and legally in a locked cabinet in the office.

Community engagement

The location of Maryfield Cottage facilitated community engagement. Residents could access Swords and Balbriggan easily for social outings and were in close proximity to services, shops, and other public amenities. Local amenities included a large shopping centre, a cinema, a library, churches, cafés, and restaurants. Residents shopped locally and visited cafés, restaurants, bingo, and the botanic gardens regularly. Residents had access to bus and taxi services. They attended day centres in the local community. A minibus could be booked by the residence to facilitate residents in accessing group community activities. An advocacy group was also available to residents by request.

Autonomy

Residents could come and go from Maryfield Cottage as they wished. They were free to determine their own bedtimes and each had a key to the front door. Residents had free access to the kitchen area. Breakfast was available between 7am and 8am, lunch was at 1pm, dinner was prepared for 5pm, and supper was offered at 9pm. A daily menu was not displayed in the dining room, but residents had input into their weekly meals and assisted with the weekly grocery shopping. Residents were responsible for their own laundry, and there was a schedule in the residence to ensure that everyone had time to use the laundry facilities. They also had daily household tasks. 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	1	1
Multi-Task Attendant	0	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	By referral
Social Worker	By referral
Clinical Psychologist	By referral

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	On request
Non-Consultant Hospital Doctor	On request

Staff had received training in Basic Life Support, fire safety, and crisis prevention intervention.

Complaints

Maryfield Cottage had a complaints policy, which was dated January 2014. The complaints procedure was displayed in the hall of the residence. The resident information folder also contained information on how to make a complaint. The process for making informal complaints within the residence was verbally to any of the staff members. The CNM2 was responsible for responding to all complaints made within Maryfield Cottage and for escalating complaints to the complaints manager, where indicated. At the time of inspection, Maryfield Cottage was not recording minor complaints that were made verbally or at community meetings or details of the follow-up to these issues. Community meetings were held every month and minutes of these meetings were kept. A suggestion box for resident use was not available in the residence.

Risk management and incidents

The residence had a risk management policy, dated January 2014, and a safety statement, dated December 2017. The policy was implemented throughout the residence. Risk assessments were completed for residents at admission and updated as necessary. Incidents were documented and reported using the National Incident Management System. The residence appeared to be physically safe. The fire extinguishers were regularly serviced and in date, and the fire escape was easily accessible. There was a first aid kit in the office.

Financial arrangements

Maryfield Cottage had a policy in relation to managing residents' finances, which was dated October 2012. The weekly charge for residents was €70, which covered accommodation, food, and utilities. Residents had bank or post office accounts and staff or family members managed residents' finances. Residents accessed their money by request and cash logs were kept for each withdrawal and expenditure. On review of the resident meeting minutes, it was documented that residents were drawing on personal funds for various communal household items such as bathroom mirrors, a sofa in the dining room, and a TV unit in the living room. There was also evidence to suggest that residents were contributing towards the refurbishment and upkeep of the communal bathroom. Residents did not contribute to a kitty or social fund. The CNM2 audited finances fortnightly.

Service user experience

At the time of inspection, no resident was available to meet with the inspector.

Areas of good practice

1. Each resident had a communication passport, which described their most effective means of communication and how others can best communicate with and support them.

2. There was strong emphasis on the provision of social and recreational activities for the residents.

3. Workshops on oral hygiene, health eating, and the importance of exercise had been held in the residence.

4. Smoking cessation programmes were available to residents.

Areas for improvement

1. The maintenance issues should be addressed as a matter of urgency.

2. Necessary renovation, deep cleaning and redecoration of the residence should be undertaken to ensure a comfortable and dignified living environment.

3. Residents should not be drawing on personal funds for communal household items and household repair. Appropriate funding should be sourced for this.

4. The service should consider the introduction of a suggestion box.

5. Any complaints received by residents should be documented so that there is clear evidence that any issues arising are acted upon.

6. A copy of all ICPs should be offered to residents or a reason should be stated as to why this did not happen.

7. ICP reviews should involve the entire clinical team.

8. Information sheets should be provided regarding health screening programmes.