Millfield House

ID Number: RES0064

24-Hour Residence – 2018 Inspection Report

Millfield House
Blackpool
Cork

Community Healthcare Organisation:
CHO 4

Team Responsible:
Rehabilitation

Total Number of Beds:
15

Total Number of Residents:
14

Inspection Team:
Noeleen Byrne, Lead Inspector

Inspection Date:
8 February 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

Millfield House was a 15-bed, 24-hour, nurse-staffed residence in an industrial area in Blackpool, Cork. The two-storey residence was owned by Cork Mental Health Association and opened as a 24-hour residence in 2002. At the time of inspection, the residence was accommodating 14 residents under the responsibility of the City North East Adult Mental Health Team. There were no immediate plans for the residence to change.

Residence facilities and maintenance

Residents in Millfield House were accommodated in three triple and three double rooms. Residents' privacy was compromised because there was no screening between the beds and the triple rooms were very cramped, with beds arranged foot to foot. The duvets were flimsy and in need of replacement.

The other accommodation included an office, visitors' room/quiet room, a games room with a pool table, a sitting room, a staff kitchen that doubled as an occupational therapy kitchen, a main kitchen, a dining room with seating for 16 people, a separate office for the clinical nurse manager 2, and a laundry room. There was no toilet seat in the women's toilet. The couch in the sitting room was shabby and torn.

The residence had a very large garden, but it was not well maintained. It was unkempt and rubbish was piled up outside one door. The entrance to the residence was through a largely disused industrial estate, leading to a car park that was used at night for a bingo hall. At the time of inspection, some improvements had been made to the kitchen. A new freezer had been ordered following a food hygiene inspection.

Resident profile

At the time of the inspection, Millfield House was providing accommodation for five female and nine male residents. They were aged between 27 and 77, and the duration of their stay ranged from 12 months to 16 years. All of the residents were fully mobile.

Care and treatment

Millfield House did not have a policy in relation to individual care planning. All of the residents had a multi-disciplinary individual care plan (ICP), and they had full input into the care planning process. Residents' ICPs were reviewed approximately every two months. The multi-disciplinary team met in the house monthly, reviewing approximately half of the ICPs at each meeting, which residents attended. However, the review sheet was placed in the clinical file, separate to the ICP. A psychiatric evaluation was documented in residents' clinical files at least six-monthly. There was a key worker system in operation in the residence, with residents assigned to a consistent named individual.

Physical care

Millfield House did not have a policy in relation to physical care or general health. All residents had access to a GP, who completed their general physical examinations on a six-monthly basis. Information was available in the house in relation to national screening programmes, and residents were receiving appropriate screening. Residents also had access to other health services by referral, including dentistry, physiotherapy, speech and language therapy, and general hospital services.

Therapeutic services and programmes

The residence did not have a policy in relation to therapeutic programmes. Residents had access to a gardening group, and the occupational therapist ran cookery classes, although there was no cookery course at the time of inspection.

Some residents also attended therapeutic programmes off-site, in Inniscarrig House on Western Road, where they accessed cooking, cognitive behavioural therapy, relaxation, medication management, literacy, and art therapy. One resident was attended National Learning Network training.

Recreational activities

Residents in Millfield had access to a variety of recreational activities, including pool, darts, DVDs, CDs, TV, puzzles, board games, jigsaws, and exercise equipment.

Medication

Millfield House had a policy in relation to medication management. Residents' medication was prescribed by the consultant psychiatrist or GP, and a Medication Prescription and Administration Record (MPAR) system was in operation. Residents' MPARs contained valid prescriptions and administration details. At the time of inspection, one resident was self-medicating. The medication was provided in a blister pack, which the resident kept securely in their bedroom. Medication was supplied to the residence by a local pharmacy, and it was stored appropriately and legally within the house.

Community engagement

Millfield House was situated in an industrial estate not far from Blackpool shopping centre, with access to a bus service to Cork city. Residents attended day services, the Stepping Stones School, a games group, exercise groups, and musical activities, and they went on visits to the library or to mass.

Residents used public transport to access day services or they paid for a taxi. The house had its own seven-seater people carrier, which was used occasionally to facilitate residents in accessing community activities. There was no community in-reach into the residence.

Autonomy

Residents did not have full access to the kitchen to prepare meals or snacks. The kitchen was only open to domestic staff, and there was no coffee dock where residents could make their own tea/coffee or snacks. Residents were free to determine their bedtimes, but none of them had a key to their own bedrooms. Residents helped with domestic activities, and rota was in place in the dining room. Visitors were welcome in the house at any time, and residents could come and go as they pleased.

Staffing

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	Weekly when delivering a course
Social Worker	Weekly
Clinical Psychologist	0

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

Staff had up-to-date training in Basic Life Support and fire safety. They did not have training in the management of aggression and violence.

Complaints

Millfield House used the HSE's *Your Service Your Say* complaints policy, and residents were aware of how to make a complaint. Complaints could be discussed at the monthly community meetings, which were minuted, or they were brought to individual staff. Staff on duty addressed issues on the spot, where possible. Any complaint that they could not address was escalated to the assistant director of nursing or the complaints officer. A complaints log was not maintained. There was a suggestion box in the house, where residents could leave anonymous comments.

Risk management and incidents

Millfield House did not have a risk management policy. Risk assessments for residents were completed at admission but were not updated regularly. Incidents were reported and documented using the National Incident Management System. The residence appeared to be physically safe. The door had to be kept locked at night when bingo was on in a nearby hall because of a potential security risk. Fire extinguishers were serviced and in date, and fire escapes were easily accessible. However, fire doors were kept open using a wedge. There was a first aid kit on the premises.

Financial arrangements

Millfield House had a policy in relation to the management of residents' finances. Residents paid a weekly charge, depending on their means, and this included food and utilities. Residents had post office or bank accounts and looked after their own financial affairs. They also had access to secure facilities in the house for the safe-keeping of small sums of money. Appropriate procedures were in place in relation to staff handling residents' money.

Residents contributed a small weekly sum to a social fund, which was used to pay for social events. There was no record that residents had signed their consent to contribute to the fund, which had been in place for a long time. Residents' finances were audited.

Service user experience

Residents were attending activities on the morning of the inspection. Later four residents described life in Millfield House. They said they were content living in the house and the sitting room where we met was very comfortable. Residents said the food was nice and some helped with setting the table and cleaning up. Residents were very complimentary of the staff and said they were very helpful.

Areas of good practice

1. Monthly multi-disciplinary team meetings were held in the house.

Areas for improvement

1. There was no toilet seat in the ladies' toilet.

2. The exterior of the building was not well maintained, and lots of rubbish had accumulated outside one door.

3. Fire doors were kept open using a floor wedge.

4. The ICP review was recorded on a single sheet that was filed separately to the ICP.

5. There were no facilities where residents could prepare tea/coffee or snacks.

6. A complaints log was not being maintained in the house.

7. The bedclothes were shabby and the duvets were in need of replacement.

8. Bedrooms were cramped and there was no privacy screening between beds. Each resident should have their own bedroom. In the meantime, privacy screens should be used where there are shared bedrooms.

9. There was no record that residents had signed their consent to contribute to a social fund.