Millview

ID Number: RES0076

24-Hour Residence – 2018 Inspection Report

Millview
Enniscorthy
Co. Wexford

Community Healthcare Organisation:
CHO 5

Team Responsible:
Rehabilitation

Total Number of Beds:
13

Total Number of Residents:
12

Inspection Team:
Dr Ann Marie Murray MCRN 363031, Lead Inspector

Inspection Date:
01 February 2018

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

Millview was a 13-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 2010. At the time of inspection, Millview was providing rehabilitation and continuing care for 12 residents.

Residence facilities and maintenance

Millview was a modern building, with accommodation arranged around a central courtyard. There were 13 single bedrooms with en suite bathrooms. There was a sitting room with a TV, books and DVDs. There was a kitchen, an attractive dining room, an activity room with foosball, a pool table, and arts and crafts materials. The activity room was not used frequently by residents; there was sparse decoration and an empty information board hung on the wall. There were two bathrooms, a storeroom, a linen room, a cleaners' room and a clinical room. Residents' paintings lined the corridors. The outside of the house was well maintained.

The sitting room walls were chipped and stained and in need of repainting, and the accessible toilet was malodorous. The residence did not have accessible showers in all rooms. Each en suite bathroom contained a shower, which had a lip/step at floor level, making it unsuitable for residents who required assistance.

Some of the residents' bedrooms looked out onto a public car park. There was no frosting on the windows or patio doors, which did not afford residents adequate privacy in their bedrooms. There was a lack of individuality in relation to the decoration of residents' bedrooms.

At the time of inspection, clinical records were being kept in a storeroom and could potentially have been accessed by nonclinical staff. The inspector advised staff that records should be secured.

Clean linen was observed to be stored in bags on the ground. Storage spaces was limited in the centre. A hoist was stored in a corridor area, food was stored in a cupboard in the activity room, and chairs were stored in a bathroom. There were plans to add a kitchenette to the activity room and to undertake some decorative work in the residence.

Resident profile

At the time of the inspection, Millview was providing accommodation for 12 male residents. They were aged between 38 and 70. Four of the residents had been in the residence since it opened with the most recent admission in January 2018. One resident was a ward of court. A number of residents had physical disabilities, and the accommodation, apart from the showers, was wheelchair accessible.

Care and treatment

Millview had a policy in relation to individual care planning, which was a Waterford/Wexford service policy and was stored electronically. Staff were unable to locate the policy, and the inspector had to show them how to access it.

Three individual care plans (ICPs) were reviewed. The ICPs were not drawn up by a full multi-disciplinary team (MDT) as there was no evidence of input from a psychologist. There was no psychologist on the MDT. Residents attended ICP reviews, which occurred every six months. Staff noted that the service was considering changing the ICP review to every three months. Residents had input into the care planning process, and their opinions were sought. Three files reviewed indicated that the resident received a psychiatric evaluation at least six-monthly.

The multi-disciplinary team met in the Killagoley Training & Activation Centre (KTAC) in St. Senan's Hospital, Enniscorthy, every week, and nursing staff attended. Nurses in the residence functioned as key workers, and a consistent named individual was assigned to residents.

Physical care

Millview used the Waterford/Wexford Mental Health Services policy in relation to physical care and general health. All residents had access to a local GP, but it was difficult to arrange home visits. On occasions, nursing staff had to wait until out of hours to get a GP appointment through an on call GP service Caredoc. In an emergency, the non-consultant hospital doctor (NCHD) could be called. Residents' six-monthly physical examinations, including electrocardiogram and blood analysis, were completed by the NCHD. Vitals were taken daily if required. The template for documenting physical examinations was very dated and not always fully completed by the NCHD. One resident did not have a physical examination recorded since admission to the centre.

Information on national screening programmes was not provided routinely. Residents were receiving appropriate screening, but this was not being systematically monitored. Residents availed of other health services in the community as required, including dentistry and optical treatment, speech and language therapy, dietetics, and physiotherapy. There was access to general hospital services in Wexford. Nursing staff had engaged a number of residents in smoking cessation programmes.

Therapeutic services and programmes

Millview used the Waterford/Wexford Mental Health Services policy in relation to therapeutic programmes. A horticulturalist attended the residence regularly to run a horticulture group, and a musician delivered a music group on-site. The occupational therapist also facilitated arts and crafts classes and was working on a collage with residents at the time of inspection.

Some residents attended KTAC in St. Senan's where they accessed games, gardening, and recreational activities. Some attended Link Training Services in Enniscorthy, which offered recreational activities and was run by social care workers. Some residents had completed a living skills course, and others had taken a literacy course.

A new recovery focused activity programme had been developed for a number of residents. There was a plan to implement this for all the other residents.

Recreational activities

Residents in Millview had access to a variety of recreational activities. These included foosball, pool, TV and DVDs, board games, books and music.

Medication

The residence used the Waterford/Wexford Mental Health Services policy in relation to medication management. Medication was prescribed by the consultant psychiatrist, GP, NCHD, or Caredoc. A Medication and Prescription Administration Record (MPAR) system was in use in the residence. Three MPARs were reviewed. One resident had been prescribed more than the maximum daily dose of paracetamol. Multiple omissions in the administration records were also identified in all three MPARs. There was no date of birth in two MPARs. At the time of inspection, none of the residents were self-medicating.

Medication was supplied from Wexford General Hospital, and it was stored securely within the residence. Nursing staff reported there was a plan to commence nursing metrics to monitor medication practices.

Community engagement

Millview was located close to the centre of Enniscorthy; however, it was segregated from the community as it was built on a hospital site. Residents went to the cinema, to the pub, on Sunday drives, and on outings to Kilmore Quay. Some residents went to the gym, and others attended an acupuncturist. The residence had access to a shared seven-seater, wheelchair-accessible minivan, which was used to bring residents to activities and appointments. There was no in-reach into the residence from the community.

Autonomy

Residents did not have full and free access to the kitchen. Residents were free to determine their bedtimes, but none of them had a key to their own bedrooms. Some of the residents helped with household chores. Residents could come and go as they wished, but there was an alarm system to alert staff when someone opened the door; there was no review of this practice. The patio doors were locked in residents' bedrooms, and staff had no clear explanation as to why they were not kept open or why residents could not have keys to their patio doors. Where a resident had a prescription for a lap belt, this was reviewed every three months. There was no monitoring or review of the use of cot sides. Residents 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
Health Care Assistant	0	0
Multi-Task Attendant	2	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	Fortnightly
Social Worker	Fortnightly
Clinical Psychologist	0

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

Staff reported they had up-to-date training in Basic Life Support and fire safety. Training in recovery techniques was ongoing at the time of inspection. Staff reported that training in the management of aggression and violence was not up to date.

Complaints

Millview had a complaints policy and used the HSE's *Your Service Your Say* complaints procedure. Residents were aware of how to make complaints, and information on the complaints procedure was displayed publicly. Staff reported that complaints were generally received in verbal form and, where possible, were addressed locally. Staff interviewed were not aware of the role and identity of the complaints officer.

The residence did not maintain a complaints log, and community meetings were not held. There was a suggestion box, but it was made of cardboard, which was torn, meaning that anybody could see its contents.

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. Resident risk assessments were not being completed when a risk had been identified or changed. Hazard identification forms were not in use.

Residents were assessed for a risk of falls, and the Sainsbury and Waterlow clinical risk assessment tools were in use. Incidents were reported and documented using the National Incident Management System. There was no trend analysis of incidents. Fire escapes were easily accessible, and fire extinguishers were serviced and in date. The service ran annual fire drills. Residents did not have personal evacuation plans. There was a first aid kit and Automated External Defibrillator in the clinical room.

Financial arrangements

Millview had a local operational policy in relation to the management of residents' finances. Residents paid a weekly charge, which covered food and utilities. Some residents' finances were managed centrally by administrative staff in St. Senan's Hospital, and others managed their own money and bank accounts. Other residents' money was managed by family members. The service did not have clear safeguarding procedures in relation to the management of residents' finances. Withdrawals from residents' funds were not always accompanied by a resident's signature or by two staff signatures.

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

Service user experience

Residents spoke to the assistant inspector during the inspection. Some of the residents commented that there was not enough staff to take residents out during the day particularly to take the residents out who were less mobile. Residents reported that staff changing frequently was hard for the residents.

Areas of good practice

1. A new recovery focused activity programme had been developed for a number of residents.

2. Nursing staff had engaged a number of residents in smoking cessation programmes.

3. The premises were well maintained externally.

4. Staff take care to facilitate residents partaking in various social activities, often in their own time.

Areas for improvement

1. There were maintenance issues that were in need of attention:

    a. The sitting room walls were chipped and stained.
    b. The accessible toilet was malodorous.
    c. The residence did not have accessible showers.
    d. Storage spaces were limited in the centre.

2. There was no frosting on the windows or patio doors of some residents bedrooms, which did not afford residents adequate privacy in their bedrooms.

3. Residents did not have access to a psychologist.

4. There were areas for improvement in relation to physical health as follows:

    (a) The template for documenting physical examinations was very dated and not always fully completed by the NCHD.
    (b) One resident did not have a physical examination recorded since admission to the centre.
    (c) Information on national screening programmes was not provided routinely. Clinical files showed residents had received national screening, but this was not systematically monitored.

5. There were a number of errors noted on the MPARS. The service may consider training and audit in medication management.

6. There were many restrictive practices which were not subject to review.

7. The residence did not maintain a complaints log, and community meetings were not held. There was a suggestion box, but it was made of cardboard, which was torn, meaning that anybody could see its contents.

8. There were areas of improvements under risk management:

   (a) Resident risk assessments were not completed when a risk had been identified or changed.
   (b) Hazard identification forms were not in use.
   (c)There was no trend analysis of incidents.
   (d) The service did not run fire drills and residents did not have personal evacuation plans.

9. The service did not have clear safeguarding procedures in relation to the management of residents' finances. Withdrawals from residents' funds were not always accompanied by a resident's signature or by two staff signatures.