Sacred Heart House

ID Number: RES0086

24-Hour Residence – 2018 Inspection Report

Sacred Heart House
Old Dublin Road
Carlow

Community Healthcare Organisation:
CHO 5

Team Responsible:
General Adult and Rehabilitation

Total Number of Beds:
9

Total Number of Residents:
9

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

Inspection Date:
08 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

Sacred Heart House was a nine-bed, 24-hour, nurse-staffed residence on the outskirts of Carlow town. The bungalow was a former nuns' home, which had been acquired by the HSE. It had been operating as a 24-hour residence for between 15 and 20 years. At the time of inspection, the residence was accommodating nine residents, all of whom had a primary diagnosis of intellectual disability. Two consultant psychiatrists were responsible for the care and treatment of the residents. One was a general adult psychiatrist and the other was a rehabilitation psychiatrist. There was no input from a psychiatrist in intellectual disabilities.

Residence facilities and maintenance

The residence comprised a central, sky-lit area with a bedroom corridor extending out on either side. The corridors were narrow. Residents were accommodated in single bedrooms with shared bathroom facilities. The bedrooms had been individually decorated to reflect residents' interests and preferences. One bedroom had been converted into a large, wheelchair-accessible shower room. The door did not have a lock on it, however. A second shower room did not have adequate space to assist residents. This shower room did not have a door but rather just a curtain opening onto a corridor. The lack of a door did not provide adequate privacy for residents when showering. A male toilet was in disrepair; there were tiles missing and rust evident.

There was a comfortable sitting room with a TV and DVDs, a dining room with seating for eight residents and a supply of jigsaws, a kitchen, and a laundry room. Papers were provided in the sitting room; however, easy to read materials or books were not evident. The residence was clean and tidy.

The outside of the house was well maintained. There was an outdoor seating area, and the garden fences were decorated with murals. There were attractive animal sculptures in the garden, as well as flowerbeds, which residents enjoyed looking after.

New beds had recently been purchased, a new bathroom had been fitted, a cement path was added to the front of the house to improve access, the fences had been painted, the interior of the house had been decorated, and new curtains, duvets, and sheets had been purchased. Plans were in place to fit a new male bathroom. Staff and residents did not have access to a computer or to the internet.

Resident profile

At the time of the inspection, Sacred Heart House was providing accommodation for four male and five female residents. They were aged between 51 and 82, and the duration of their stay ranged from 4 months to 19 years. The majority of residents had been in mental health services for a number of years. Recently, the service had begun using one of the beds as a respite bed. All of the residents had a primary diagnosis of an intellectual disability, some had a secondary diagnosis of mental illness, and a number had physical disabilities and mobility issues. The level of intellectual disability ranged from mild to severe which indicated there was a very mixed range of needs. Appropriate accommodation was available for residents with physical disabilities. The narrow corridors may present a difficulty to a wheelchair user.

Care and treatment

Sacred Heart House used the Carlow/Kilkenny and South Tipperary policy in relation to individual care planning. Three individual care plans (ICPs) were reviewed. One ICP had input from the full multi-disciplinary team (MDT), and two had nursing input only. There was no evidence of residents' involvement in any of the ICPs reviewed, and nursing staff reported that residents' communication difficulties made it difficult for them to participate in the care planning process.

In two cases, there was no evidence that the ICPs had been reviewed in almost a year. The MDT met in the day hospital, but it was not clear how regularly the meetings took place. Residents did not attend MDT meetings, but nursing staff did. There was no key worker system in operation in the house.

The residents' primary care needs related to their intellectual disability, yet there was no input from staff who had training or a specialist qualification in intellectual disabilities. There was no evidence of augmented communication techniques to support residents with communication difficulties. Staff were planning to implement communication passports but this had not yet started. Residents presented with challenging behaviour. One resident had a behavioural chart but nobody was monitoring or reviewing the entries. There was no positive behavioural support plan in place for any of the residents.

Physical care

Sacred Heart House used the Carlow/Kilkenny and South Tipperary policy in relation to physical care and general health. All residents had access to their own GPs, and most were registered with the same GP. The residents had ready access to the GP, who visited the house when necessary.

Staff reported residents received general physical examinations once annually by the GP; however, these examinations were not evident in the clinical files inspected. Information was provided verbally to residents in relation to national screening programmes. Residents were facilitated to receive national screening programmes, but this was not being actively monitored.

Residents also had access to other health services as required, including dentistry and optical treatment and general hospital services in Kilkenny. One resident required home enteral nutrition care, but the service was not available. The dietetics service had been recently withdrawn for this resident.

Breakfast and tea were prepared in the centre; dinner was provided by an external catering company. The catering company did not provide minced diets, which meant staff then had to chop the food to desired consistency. The dinners provided by the catering company were always accompanied by potatoes and two vegetables, which meant there was a lack of variety of wholegrain carbohydrates. A copy of the two-week tea menu indicated that there was minimal reference to fruit and vegetables on the menu, which consisted of primarily frozen food such as fish fingers, pizza and chicken goujons.

Therapeutic services and programmes

Sacred Heart House used the Carlow/Kilkenny and South Tipperary policy in relation to therapeutic programmes. No therapeutic programmes were delivered in the residence. Some residents attended the Dolmen Centre, an activity centre run by mental health services, which offered programmes in painting, rug-making, and arts and crafts but was not a specialist service for people with intellectual disability. Others attended the Castle Centre, where they accessed activities that included arts and exercise and used the multi-sensory room. The Castle Centre was run by mental health staff and not by an intellectual disability service. An assessment was not documented to indicate if the service provided met the needs of the residents.

Recreational activities

Residents had access to a range of recreational activities in the house, including TV, DVDs, colouring, jigsaws, and gardening.

Medication

Sacred Heart House used the Carlow/Kilkenny and South Tipperary policy in relation to medication. Residents' medication was prescribed by the non-consultant hospital doctor, consultant psychiatrist, or GP. A Medication Prescription and Administration Record (MPAR) system was in operation in the residence, but not all of the residents' MPARs contained valid prescriptions and administration details. In one MPAR, a phoned-in medication order was not signed by the registered medical practitioner (RMP), a sticker from the pharmacist was used as a prescription without a doctor's signature or Medical Council Registration Number (MCRN), an error in a medication dosage had not been rewritten when it was corrected, and medication was stopped by a nurse without a note from the RMP. In addition, the MCRN was not recorded for two RMPs. In a second MPAR, there was no MCRN or signature for two prescriptions and a stop date had not been recorded for two medications. There was evidence that chemical restraint was being used to manage residents' challenging behaviour. There was no acknowledgement of this practice or documented review and monitoring of this.

At the time of inspection, no residents were self-medicating. Medication was provided by a local pharmacy in one-month supplies, and residents paid the prescription charges. Medication was stored in individualised boxes, which had residents' photographs on them.

Community engagement

The location of the residence facilitated community engagement, but most of the residents required supervision for outings. An outings book was maintained in the house, and it indicated that, at the time of inspection, there had been two outings in the past month. Staff noted that trips out were limited due to residents' lack of mobility. Some residents went into town independently and visited the bank, went to mass, went to the hairdresser, and visited friends.

Residents did not avail of local public transport. The residence had its own seven-seater people carrier, but residents with mobility issues could not easily get into the back seats and the vehicle was not large enough to accommodate all of the residents at the same time. There was no in-reach into the residence from the community.

Autonomy

Residents had free access to the kitchen, and some were able to make their own snacks or tea. Residents were free to determine their bedtime, but none of them had a key to their own bedroom. Staff said that they would consider installing thumb locks on bedroom doors. Residents participated in household chores, including shopping, setting and clearing the table, sweeping the floor, and taking out the rubbish.

Residents who were able could come and go as they wished, and visitors were welcome at any time.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager 2	1	0
Registered Psychiatric Nurse	1	1
Health Care Assistant	0	0
Household staff	1	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	As required
Clinical Psychologist	As required

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	As required, no regular routine visits
Non-Consultant Hospital Doctor	Twice a year and as required

Staff reported they had received training in Basic Life Support, fire safety, and the management of violence and aggression. Staff reported they had not received training in working with people with intellectual disabilities. No registered nurses in intellectual disabilities worked in the residence. There was no access to a speech and language therapist for communication assessments despite many of the residents having identified communication difficulties.

Complaints

Sacred Heart House used the Carlow/Kilkenny and South Tipperary policy in relation to complaints. Staff explained to residents verbally how to make a complaint. Staff reported any complaints were addressed locally where possible. If a complaint required escalation, staff reported it was progressed to the clinical nurse manager 2 and then to the complaints officer. A complaints log was maintained in the house, but no complaints had been logged. Community meetings took place in the residence every three or four months, and minutes of these were maintained. There was no suggestion box on the premises.

Risk management and incidents

Sacred Heart House used the Community Healthcare Organisation 5 policy in relation to risk management. Risk assessments, including falls assessments, were completed for residents. Two clinical files had a Sainsbury risk assessment form, but neither assessment contained a risk management plan. Incidents were

reported and documented using the National Incident Management System, but there was no system in place for reviewing trends.

There were no internal fire doors or evacuation plan. Many of the residents had mobility difficulties. Fire extinguishers were serviced and in date. A key was required to exit through the back doors, which were not fire doors. Fire drills occurred every four to five months. The inspector advised the service to assess their fire safety requirements and to determine the need for internal fire doors. There was a first aid kit on the premises.

Financial arrangements

Sacred Heart House had a policy on the management of residents' finances. All residents paid a weekly charge, according to their means. Only one resident had a bank account and was deemed to have the capacity to manage their finances. The HSE managed the accounts of the other eight residents and lodged their money into the household account, which was then managed by nursing staff in the house. Staff did not always sign when they were lodging money or withdrawing money from residents' funds kept in the residence. Residents' clothing was sent to private laundries, which incurred an additional financial cost to the residents. It was not clear if residents' weekly rent already covered the cost of laundering their clothes. It was not evident that residents consented to their clothes being laundered privately or if their capacity to consent was considered.

Residents did not contribute to a kitty or social fund. Residents' finances were audited regularly.

Service user experience

On the day of inspection, the residents who chose to interact with the inspector were non-verbal. They appeared content and were observed to interact positively with the staff of the residence.

Areas of good practice

1. Many improvements had been made to the premises and facilities and comprised:

   (a) New beds
   (b) New accessible shower room
   (c) A cement path was added to the front of the house to improve access
   (d) The fences had been painted
   (e) The interior of the house had been decorated
   (f) New curtains, duvets, and sheets had been purchased.

2. Community meetings took place in the residence every three or four months.

3. Staff were observed to have positive interactions with the residents.

4. The bedrooms were individually decorated and reflected residents' preferences and interests.

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. Staff providing care to these residents should have training in how to meet the specific needs of residents with intellectual disabilities.

3. While the premises were generally well maintained, a second shower room did not have adequate space or privacy and a male toilet was in disrepair.

4. It was not evident that the MDT developed the ICP or how frequently ICPs were reviewed.

5. There was an identified unmet need for a dietetic service for one resident and no access to a speech and language therapist for communication assessments despite many of the residents having identified communication difficulties.

6. The food provided in the residence did not reflect the Healthy Eating Guidelines and Food Pyramid from the Department of Health.

7. It was not possible to ascertain if residents' physical needs were assessed regularly due to lack of documentation of assessments.

8. The therapeutic services provided were not targeted towards the needs of those with an intellectual disability.

9. There were many issues identified in relation to medication management; staff should consider training and audit in this area.

10. There was evidence that chemical restraint was being used to manage residents' challenging behaviour. There was no acknowledgement of this practice or documented review and monitoring of this.

11. The residence had its own seven-seater people carrier, but residents with mobility issues could not easily get into the back seats and the vehicle was not large enough to accommodate all of the residents at the same time.

12. Two clinical files showed evidence of the use of the Sainsbury risk assessment tool, but neither contained a risk management plan. There was no system in place for reviewing trends.

13. There were no internal fire doors or evacuation plan, even though some residents had mobility challenges. The inspector advised the service to assess their fire safety requirements and to determine the need for internal fire doors.

14. Staff did not always sign when they were lodging money or withdrawing money from residents funds kept in the residence. Staff were advised to review the practice of sending residents clothing to a private laundry.