Walnut Grove

ID Number: RES0044

24-Hour Residence – 2018 Inspection Report

Walnut Grove
Creagh
Ballinasloe
Co. Galway

Community Healthcare Organisation:
CHO 2

Team Responsible:
Mental Health Intellectual Disability

Total Number of Beds:
6

Total Number of Residents:
5

Inspection Team:
Mary Connellan, Lead Inspector

Inspection Date:
23 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

Walnut Grove was a six-bed, 24-hour, nurse-staffed residence in a rural setting close to Ballinasloe, Co. Galway. The single-storey residence was owned by the HSE. It was originally a private home built for a wheelchair user. It had been operating as a 24-hour residence since 2004. At the time of inspection, Walnut Grove was providing continuing care for five residents with an intellectual disability. There were no immediate plans for the residence to change.

Residence facilities and maintenance

Residents in Walnut Grove were accommodated in three double bedrooms and one single, which was a room that had been repurposed for use as a bedroom. The single bedroom had formally been a changing room and had been used regularly for residents as it was situated beside the bathroom. It also contained an examination table. There was no privacy screening between the beds in the shared bedrooms, which was not conducive to resident privacy.

There was a large, open hallway with two adjoining but separate sitting rooms with a TV in each. The kitchen-dining area was off one of the sitting rooms, through an arch. One double room was fitted with a hoist and had an en suite bathroom facility; another double bedroom had an en suite bathroom, but the shower was not in use; and the third double had a shower that was not suitable for use by residents with physical challenges.

There was a roomy communal bathroom with a bath, shower, toilet, and wash-hand basin. Just one shower in the house was suitable for resident use. There was also a laundry room and a medication station, but there was no separate medication fridge.

The exterior of the residence was well maintained by staff from St. Brigid's Hospital in Ballinasloe.

Resident profile

At the time of the inspection, Walnut Grove was providing accommodation for two female and three male residents. They were aged between 58 and 88, and the duration of their stay ranged from 18 months to 14 years. A number of the residents had physical disabilities, and the accommodation in the house was suitable for their needs. There were hoists in two rooms and staff also had access to a portable hoist.

Care and treatment

Walnut Grove had an out-of-date policy folder, and there was no policy in relation to individual care planning. All of the residents had a "hospital passport", which identified their needs. There was evidence that these were reviewed weekly.

Residents did not have a multi-disciplinary individual care plan (ICP), although plans were in place to introduce ICPs and a review system. Residents had input into care planning, where applicable. Health care assistants fulfilled the role of residents' key workers and had a very good understanding and respect for the individual care needs.

There was evidence in the clinical files that the consultant psychiatrist saw the residents at least every six months, but a six-monthly psychiatric review was not documented in any of the files. Multi-disciplinary team (MDT) meetings were not held in the residence; they were held weekly in St. Brigid's Hospital in Ballinasloe. Plans were in place to rotate the MDT meetings among the nine houses in the service area. Residents and nursing staff could attend MDT meetings.

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

Walnut Grove did not have a policy in relation to physical care and general health. All residents had access to a local GP. Routine physical examinations of residents were completed by the GP annually or more often if required. These were noted in the residents' clinical files.

No information in relation to national screening programmes was provided in the residence. Staff were unsure whether residents were receiving appropriate screening programmes, and there was no record of this in the clinical file examined.

Residents had access to other health care services, in the general hospital and by referral from the GP. At the time of the inspection, a speech and language therapist had just been added to the service.

Therapeutic services and programmes

Walnut Grove did not have a policy in relation to therapeutic services and programmes. An art therapist attended the residence every week, and some residents attended therapeutic programmes off-site, including in the Deerpark day centre in Ballinasloe.

Recreational activities

Residents in Walnut Grove had access to a variety of recreational activities, including TV, books, and newspapers. They also went on bus trips and visited coffee shops and went out to eat.

Medication

Walnut Grove had a policy in relation to medication management. Medication was prescribed by the residents' GP or the consultant psychiatrist and transcribed into the Medication Prescription and Administration Record (MPAR) by the non-consultant hospital doctor. Each resident had an MPAR, but these were maintained on poor quality paper and could tear. The MPARs allowed for six months of prescribing, and dates of discontinuation were not specified when medication was no longer administered to a resident.

At the time of inspection, no residents were self-medicating. Medicines were provided by a local pharmacy, which visited the house periodically to conduct a stock check and remove out-of-date or unused medications. Medication was stored appropriately and legally within the house.

Community engagement

Walnut Grove's rural location, some distance from the centre of Ballinasloe, did not facilitate community engagement. Residents needed support or accompaniment to engage in community activities and they travelled with staff by bus if they were going out.

There was no in-reach into the residence from the local community.

Autonomy

Residents had full access to the kitchen but were always supervised by staff. Residents were free to determine their own bedtimes, and they could receive visitors at any time. Residents were not restricted in terms of when they could leave the residence, but it was appropriate for them to be accompanied by staff when they did so.

Staffing

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

There were usually three Health Care Assistants for the residence. On the day of the inspection, one resident was temporarily in another health care facility and the staff compliment was reduced to two.

*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. On the day of the inspection, the staff nurse was an agency nurse and was acting in capacity as the clinical nurse manager. No staff were qualified in the field of Intellectual Disability.

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

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

Complaints

Walnut Grove had a policy in relation to complaints and used the HSE complaints procedure, *Your Service Your Say.* Residents were informed of how to make a complaint. There was a nominated complaints officer, and a complaints log was well maintained. There was a suggestion box in the residence.

Community meetings were not held in Walnut Grove.

Risk management and incidents

Walnut Grove had a policy in relation to risk management, but it was not being implemented throughout the residence in a structured manner. Some residents had not been risk-assessed for some years, and risk assessments were completed as required rather than routinely. For example, falls risks and risks associated with social outings were assessed only when identified. Incidents were recorded in an incident report book and reported to the clinical nurse manager (CNM) 2.

The residence appeared to be physically safe, and the fire exits were accessible. The fire extinguishers were serviced regularly and in date. There was a first aid kit in the kitchen.

Financial arrangements

Walnut Grove did not have a policy in relation to residents' finances. There was a set weekly per-person charge which included rent and food. Residents also paid separately for heating oil. Residents had credit union or post office accounts, and appropriate procedures were in place in relation to staff handling residents' money, with two staff signing for all transactions. The CNM 2 signed off on all transactions on a monthly basis.

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

Service user experience

The inspector chatted informally with the residents throughout the inspection process. There was a friendly warm ambience in the residence and the residents appeared content and well cared for.

Areas of good practice

1. 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.

2. An Art Therapist visited the house weekly and it was reported that the residents enjoyed this intervention.

3. The residents were very well care for by the care staff. They knew the residents well and showed great understanding and respect towards their individual care needs.

Areas for improvement

1. A former changing room/examination room had been re-purposed for use as a bedroom. It contained an examination table also.

2. There was no medication fridge in the residence. The MPARs were on very poor quality paper. Not all medications that had been discontinued were denoted by the date.

3. Each resident should have their own bedroom. In the meantime, privacy screens should be used where there are shared bedrooms.

4. There was no information regarding National Screening Programmes and staff were unsure whether residents had received appropriate screening.

5. The shower facilities required upgrading and were not suitable for the resident profile. There was only one shower that was suitable for usage by all the residents.