Tulla Hill

ID Number: RES0019

24-Hour Residence – 2019 Inspection Report

Tulla Hill
Loughrea
Co Galway
H62 D767

Community Healthcare Organisation:
CHO 2

Team Responsible:
Rehabilitation and Recovery Service, led by Consultant Psychiatrist Dr Spellman.

Total Number of Beds:
6

Total Number of Residents:
6

Inspection Team:
Martin McMenamin, Lead Inspector
Sarah Moynihan, Assistant Inspector

Inspection Date:
25th April 2019

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

Tulla House has been operating as a staffed supervised residence under the auspices of the Health Service Executive (HSE) for circa 20 years. Tulla House was situated within an urban area on the western outskirts of the town of Loughrea. The services provided at the community based residential facility was part of the Rehabilitation and Recovery service, led by a consultant psychiatrist.

Some current residents had been admitted following assessment from acute adult mental health care teams, whilst a number of other residents had been in residence in excess of 14 years and viewed the facility as their home. At the time of inspection residents were subject to suitability assessment in terms of what would constitute their most appropriate care setting based on their needs, abilities and wishes. The likelihood was that, some residents will transition to lower support houses, or more independent accommodation in the future. For others it was their home, where it was recognised that they may require increasing levels of mental and physical healthcare support going forward.

Outreach support (night time medication management and budgeting) to two external residents - low support hostels/housing association (An Tua) previously provided by the staff at Tulla House, were being reduced.

Residence facilities and maintenance

Tulla House was an ‘L’ shaped dormer bungalow and was not purpose built and had required adaptation over the years. There was a single staircase to the two story dormer extension.

There was accommodation for 6 beds in 5 bedrooms; however, there was only one resident in each double room, as one resident had been transferred and a bed in double room had become vacant. There were tentative plans to change the upstairs double bedroom into single accommodation and make part of it into an additional storage area. The house had access to 4 toilets and 2 showers. However, a shower in the en suite double room downstairs was not functioning and was in a poor state of repair.

The house would benefit from painting. The house also was inadequately safeguarded against anti-social behaviour, as there was no gate to the property and there was a paucity of external security lighting. There was an impoverished boundary railing and there was a degree of risk associated with a previous road traffic accident and cars coming into contact with the boundary wall.

The grounds were observed to be overgrown, although a new contractor had been identified for grass cutting. The garden shed which houses the laundry appliances was unsuitable in terms of safe access: there was a low roof on the shed and it could not be guaranteed to be warm at night or in winter.

Corridors within the house were narrow even for residents and staff to pass, this would be compounded if a resident required the use of a mobility aid. Arrangements were made for one resident to be accommodated in a bedroom downstairs, as hip issues had reduced their ability to use stairs or travel distances.

Some renovations and refurbishments had been undertaken and included: a new disabled ramp to the front and rear of the house had been installed; a new exit door from the nursing office to the front of the house had been provided to improve safety. Although there were plans to refurbish the en suite in the bedroom downstairs, it would be better if it was enlarged and totally upgraded to be used as an assisted bathroom, should such a need arise in the future.

Although not an issue solely applicable to Tulla House, the water quality was poor generally within the locality and was being monitored by the Environmental Health Officer. Residents had access to bottled water.

Given the modern requirements of similar accommodation needs, Tulla Hill would not be deemed best suited for purpose. A key rationale was that it will not suit the future physical needs of the existing residents. It also needs improved insulation, damp-proofing, improved lighting internally, provision of security lighting externally a more modern fire alarm system, and major structural improvements to facilitate laundry and resident (training) kitchen facilities as well as improved storage. Corridors were also narrow and the single narrow stairway risks compromising resident safety upstairs as there was also a storage area under stairs-which constituted a potential fire risk.

Resident profile

There were 6 residents living in the house, three male and three female. One of the residents was currently an inpatient within Portinuncula Hospital (thus on the day of inspection there was 5+1 residents). The age profile ranged from 42 years to 65 years. Resident duration of stay ranged from 14 years to 17 days. The last admission had been two weeks prior to inspection. There had also been one resident death and one discharge in the previous month. All were mobile and did not require support in this respect.

Care and treatment

There was a policy on individual care planning and all residents had an individual care plan (ICP). All residents were cared for by the Rehabilitation and Recovery team under a Consultant Psychiatrist. A key worker was assigned to each resident. The team had a full-time Occupational Therapist, a Social Worker, a Senior House Officer and a consultant Psychiatrist, however there was no access to a Psychologist.

The ICPs and supporting clinical notes provided evidence of psychological, physical, vocational, social/ interpersonal, as well as, the identification of early warning signs and Activities of Daily Living assessments. Resident strengths and achievements were also noted within the documentation. Risk assessment was undertaken at time of admission and this was reviewed whenever the resident was reviewed by the mental health team.

Care Plans were reviewed on a three to six monthly basis and were linked to the key worker rota. Evidence of service-user input in the form of comments and signature was evident in the care plans. A psychiatric

evaluation was documented in the file at least six-monthly. Multi-disciplinary team (MDT) meetings were undertaken off site. Residents and families were not invited to the MDT meetings, however residents attend the care plan meetings and family members (with permission of the client) are invited and encouraged to attend the recovery care plan meetings. These meetings occurred in the Day Hospital and in the residence. Staff in the residence presented as committed in delivering best care and were observed to be supportive and involved with residents.

Physical care

There was a policy on physical care and general health. All but one resident was registered with a GP - this resident did not have a medical card, and their physical health needs were met by the medical staff on the team. General physical examinations were undertaken every three-six months by the GP for all other residents.

Clinical records indicated regular blood analysis, including Fasting Glucose and blood lipid assessment.

Residents received information and had access to appropriate national screening programmes. Residents also had access by referral to other health services, where required, such as chiropody, occupational therapy, general hospital services and other community services.

Therapeutic services and programmes

There was a policy on therapeutic programmes. Staff co-ordinated resident involvement in external therapeutic activities, either in the local day centre, a training centre within the town or in other educational facilities. The GP referred residents to therapeutic activities which had a more physical component following a physical assessment, as appropriate. Medication management support was given to two residents.

The therapeutic activities that were mostly delivered off site as part of the wider Rehabilitation and Recovery team programmes included:

- Employability access programme
- Back to work programme
- Sheltered workshop
- Library
- Social Farming
- Driver theory test

Recreational activities

There were recreational activities available in Tulla House. Within the residence activities included reading, television including a subscription satellite service, small gardening work and walks and there was also a Sensory Tool Box for residents to explore.

Residents also went on trips away, had lunch outings, attended bingo or went swimming. The residence

Also had access to its own transport, a Multi-Purpose Vehicle (MPV) which was well maintained and for which a log of travel was recorded.

Medication

There was a policy on medication management and staff had access to a Drugs and Therapeutics Committee. Medication was prescribed by either the residents NCHD, Consultant Psychiatrist or GP. There was a Medication Prescription and Administration Record (MPAR) for each resident, which contained valid prescription and administration details. On review of the MPARs however, it was observed that not all MPARS identified actual or potential allergies.

Residents managed their own administration of medication via blister packs supplied by a local pharmacist. These were appropriately and legally stored in a locked cupboard within the nursing office. Nursing staff only signed for depot medication and 'as required' medications. A Community medication record was also maintained.

Community engagement

The residence was located a relatively short distance from the centre of Loughrea and residents had free access to the town and facilities. The residence was also located in an area of large housing estates, 2km from a local church/ and 1km from the shop with a footpath assisting safety. Access to other local facilities generally required transport especially if there was heavier shopping etc. A number of residents went out for a drink or to bingo on a regular basis. Whilst there was local transport available that residents could use, the residence had use of a people carrier to access community activities. Once in Loughrea there was access to further local transport. There was no identified community in-reach to the residence or residents.

Autonomy

Residents had free access to the kitchen to prepare meals or snacks, with assistance if necessary. Residents were also free to determine their own bedtime. None of the residents had the facility to lock their room or to secure personal property adequately. Staff however, facilitated bedrooms to be secured when requested. Residents assist with domestic activities (weekly shopping, maintenance of the residence). Residents could receive visitors at any time and were free to come and go from the residence as they wish. For most of the

inspection residents were not present as they were engaged in activities away from the house. A number of residents also maintained their own mobile phone.

Staffing

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	On request
Social Worker	On request
Clinical Psychologist	Not available

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	The Consultant Psychiatrist attends every three weeks (scheduled) and is available on other occasions when clinical issues require a review.
Non-Consultant Hospital Doctor	Available daily

Staff had received training in:

- Basic Life Support
- Fire safety
- Prevention and Management of Aggression and Violence
- Recovery Principals and Practice Workshop

Training records also indicated that staff had also participated in National Incident Management training and in the HSE Good Practice Guidelines.

Complaints

The residence has a complaints policy and used the HSE 'Your service, your say' protocols. The complaints process was displayed on the noticeboard. The clinical nurse manager 2 was responsible for the initial

handling of complaints. There was a complaints log. Community meetings were held although these were infrequent. Minutes were maintained and available for inspection. There was no available suggestion box.

Risk management and incidents

The Service's risk management policy was implemented in the residence and staff were able to articulate processes and schedules of risk assessment. The inspection identified that risk assessments were carried out for residents and regularly reviewed by the multi-disciplinary team in relation to:

- FACE health and social assessments
- People handling – risk assessments
- Brief psychiatric risk assessment.
- Physical health assessments including falls.

Incidents were initially communicated to the CNM2 or person in charge and also reported via the National Incident Management System (NIMS), where they were assessed and rated.

The residence has clear access to exit doors and there was adequate firefighting equipment – available extinguishers were in date. There was a first aid kit as well as, a mini-mask to aid cardio pulmonary resuscitation (CPR). Fire safety and staff safety had been improved with the addition of a patio door to the rear and additionally within the nursing office. However the stairway risks compromising resident safety upstairs as it was narrow and there was a storage area under stairs exposing a potential fire risk.

Further risk assessments should be undertaken in relation to the physical safety of the residence including: the location of the residence, near a junction where cars had previously crashed into the boundary wall; anti-social incidents relating to the residence and staff cars – for example, stone throwing; the lack of proper external security lighting and / or cameras and no gate on the main entrance to maintain the integrity of the site.

Financial arrangements

There was a policy on managing residents' finances, personal property. Residents paid a monthly fee which covered food and utilities and a subscription satellite service. Each resident had been financially assessed and all residents had their own private bank or post office accounts.

Some residents managed their own money, whereas others were assisted by staff. Resident's cash and transactions were recorded in a book with a cash sheet signed by both staff and resident, and their banking tasks were supported by staff. Appropriate procedures were in place for staff handling residents' money. Staff maintained individual amounts of money for residents. Amounts drawn down reflected what was requested or anticipated for residents' needs.

One resident has a power of attorney identified. Staff maintained a running total of what was spent, with all resident's finances audited and monitored by the CNM2 with oversight from the Assistant Director of Nursing.

Service user experience

For most of the inspection residents were not present as they were engaged in activities away from the house.

Areas of good practice

1. Residents care needs aligned with an established rehabilitation and recovery ethos.
2. All residents had an individual care plan and a schedule of meaningful activities.
3. Staff in the residence presented as committed in delivering best care and were observed to be supportive and involved with residents.

Areas for improvement

1. All sleeping accommodation should be in single rooms.
2. Medication prescription and administration must meet legal and professional requirements.
3. Further risk assessments should be undertaken in relation to the physical safety of the residence.
4. The residence did not reflect the best accommodation, location and facilities standards of a modern mental health facility offering rehabilitation and recovery.
5. There should be a maximum of four residents, all of whom choose to share accommodation and live together.