Teach Follaine

ID Number: RES0283

24-Hour Residence – 2020 Inspection Report

Teach Follaine
Kilcullen
Co. Kildare

Community Healthcare Organisation:
Independent

Team Responsible:

Total Number of Beds:
10

Total Number of Residents:
10

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

Inspection Date:
9 July 2020

Inspection Type:
Announced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 20 May 2021

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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

Teach Follaine began operating in June 2019. The property was formally a Nua residence for Intellectual Disability (Chapel View) and was under the remit of HIQA. Managed by Nua Healthcare Services, it was a ten bed, two storey, community-based mental health residence. Its stated remit was to provide rehabilitation and continuing care services. It was based in a renovated property, in a rural location outside Kilcullen, Co. Kildare. The residence's doors were locked using a key code system and residents were provided with the codes to the doors, unless otherwise risk assessed. On the date of inspection, three residents did not have access to the door code for the main doors due to their risk assessment.

Residence facilities and maintenance

There were no shared bedrooms as the residence had ten single, en suite bedrooms. There were also two communal sitting rooms, one kitchen, a dining room, and an enclosed garden. Both the dining room and the sitting rooms could hold ten persons each.

The residence was refurbished prior to its opening. Works included the installation of the fire detection and suppression systems, as well as an upgraded water management system, heating and electrical systems, en suite and laundry facilities, as well as improved kitchen facilities and general décor. Ongoing building and grounds management included general maintenance, repairs, and servicing by an in-house team. Adequate infection prevention and control precautions were in place for COVID-19. A disinfectant foot bath was provided at the entrance, as were temperature checks, hand washing facilities, and a visitor register that included contact details. There was a power outage for 90 minutes during the inspection, resulting in the passenger lift and the toilet and water taps being inoperable for resident use. There was no provision of a back–up generator. Ramps and safety handrails were noted at the fire doors and there was a safety chair in the shower for one resident. However, the corridor upstairs was narrow. CCTV cameras evident in the two main corridors were reported as not being active. Residents have access to centre laptops which are connected to the WiFi, all residents have personal smart phones with internet access.

Resident profile

There were ten residents at the time of the inspection with an age range of between mid-twenties to late fifties. The average length of a resident's stay at the residence was based on the resident's needs and rehabilitation plans. One resident had transitioned from the intellectual disability service that the residence had formally supported. All residents have a primary mental health diagnosis, and the residence catered for persons with intellectual and physical disabilities. One of the residents was registered as a Ward of Court and another resident was on Section 26 leave of the Mental Health Act. Residents with a physical disability were offered accommodation on the ground floor. However, as noted, the lift in main centre of the building did not work when there was a power outage.

Care and treatment

The residence had a policy on individual care planning and all residents had an individual care plan (ICP). ICPs were completed in full consultation with the resident and aimed to capture their goals and aspirations. Residents were supported as appropriate by the operations managers, key workers, and their multi-disciplinary team (MDT), albeit off-site, in Naas and Supported by a full-time staff nurse on site. Residents had the opportunity to and were encouraged to engage in their care plan review meetings. ICPs were generally reviewed at least every three months or more frequently. Psychiatric evaluations were carried out by a psychiatrist bi-monthly.

MDT meetings were held on the second week of transition between the Managers and Clinical Team, as well as on week 12 of admission (with full MDT, family and resident). An MDT meeting was also held annually, thereafter unless specified, requested or required more regularly. Residents were allocated two key workers. MDT meetings were sometimes located in Teach Follaine and attended by residents. When MDT meetings were not located in the residence, residents could attend the alternate location at Nua Healthcare's Clinic Department in Naas and were assisted by nursing staff where required or could attend via video link. As a result of COVID-19, phone consultations were now conducted four times per month, or when required. One ICP was reviewed on inspection and outlined a behavioural plan that inappropriately linked smoking rewards with absence of nocturnal enuresis.

On interview, the staff indicated that there could be up to 10-11 episodes of physical restraint each month. Observation of the recorded episodes in the incident log identified that most related to verbal aggression, destruction of property, and aggression towards staff. Each episode of restraint was described as being of a very short duration. First level response was described as engaging de-escalation and re-direction interventions. Staff were trained in Management of Actual or Potential Aggression (MAPA). Holds were described as being 'medium standing holds'. One staff member took the lead, and a body check was undertaken by the RPN afterwards. A body map diagram was used to describe any injuries or pain. The resident was not usually medically reviewed by a registered medical practitioner (RMP). The incidents were recorded and subsequently reviewed by the Operations Manager (OM) and the Registered Psychiatric Nurse (RPN) and, additionally, by the Director of Operations and the Risk Department at Nua headquarters.

Physical care

The residence had a policy on physical care and general health and all residents had a GP. General physical examinations were carried out by a GP on admission to the residence and, thereafter, every six months. Residents could avail of their GP when and as required. Information was accessible to residents on the various screening programmes available to them, and residents received appropriate screening. Residents had access to other health services, including a physiotherapist, dentist, dietitian, speech and language therapy, and general hospital services.

Therapeutic services and programmes

The residence had a policy on therapeutic programmes. Therapeutic programmes were not delivered in the residence by members of the MDT. However, residents generally attended off-site therapeutic programmes such as the Johnson Centre in City West or the Platinum Day Services. However, as a result of COVID-19 and associated restrictions, this was not the case at the time of inspection.

The residence operated on social and behavioural care models, with any mental health care provided being operated on the lowest levels of therapeutic interventions and support. Clear rehabilitation and recovery goals and interventions were noticeably absent from residents' daily programmes and activities. One resident's daily activity was 'Look at fish' and 'Feed the cat'.

Culturally, a poster on the information board could be interpreted as prescriptive and covertly controlling, i.e. not couched in the context of mutual respect or personal responsibility. For example, statements included: 'Say please and thank you'; 'No shouting or screaming'.

Recreational activities

The residence had a daily activity list. Recreational activities, including arts and crafts, gardening, baking, reading, knitting physical exercise, board games, bingo, and barbeques when the weather permitted. There was internet access for activities within the residence. Residents were offered activities at a weekly resident forum and when completing their weekly planners.

Medication

The residence had a policy on medication management. The consultant psychiatrist and GP prescribed medication, which was administered by a nurse, social care workers, or assistant support workers. At the time of inspection, no residents were self-medicating. The residents' medication, prescription and

administration record (MPAR) contained prescription and administration details. MPARS were not composite documents. Medications were stored in a purpose built, resident-specific medication storage unit that consisted of a lockable unit within a restricted access office. Temperature controlled drugs were stored within a lockable fridge. Inspectors noted the significant improvement in the reduction of medication recording incidents since the beginning of the year.

Community engagement

Staff support residents to access and integrate within local communities in line with individualised care plans and documented personal objectives, goals, and aspirations, with a focus on rehabilitation, independence, and community inclusion. Residents attended and partook in community activities, including the local shops, the church, employment and educational programmes, day services, outreach programmes, social and sporting clubs, outreach employment, and walking groups. However, due to COVID-19, most community access was postponed. Residents had access to various transport options, such as taxis, three residence vehicles, buses, and trains. Community in-reach was provided by HSE social workers, disability managers, care managers, and advocates.

Autonomy

The main doors of the residence were locked, entry and exit was by way of a key code on the front and back doors. Of the ten residents, three did not have access to the code for the main doors due to risk. This risk assessment indicated that it was unsafe for these residents to have unsupervised access and egress from the house (some residents required support staff on a one-to-one or two-to-one basis). The remaining residents were free to leave the residence as they wished, again based on a risk-assessment.

Residents had free access to the kitchen at all times and were able to determine their own bedtime. All residents could have a key to their own bedroom, however only three residents have chosen to do so. Residents assisted with domestic activities and could normally receive visitors. However, due to COVID-19, required restrictions had been put in place. All residents had their own mobile phones. A service–user committee had been established.

Staffing

The service had a dedicated Operations Manager, two Deputy Operations Managers, shift leads when managers were not on-site, and access to management support through an established On-Call System on a 24/7 basis. The centre also had a full-time staff nurse. The Person in Charge was located on the premises from 09.00 – 17.00 daily and on-call thereafter.

It was reported that all staff had received training in Basic Life Support; fire safety; recovery, and; prevention and management of aggression and violence.

Staff Discipline	Day whole-time equivalent (WTE)	Total WTE
Operations Manager	1	1
Deputy Operations Manager	2 (opposite shift)	2
Registered Psychiatric Nurse	1 with protected time of 24 hrs per week	0.6
Health Care Assistant	9	16
Social Care Worker	6	12

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	Indirect -via centrally based NUA Clinical Care Team – advisory.
Social Worker	Indirect -via centrally based NUA Clinical Care Team – advisory.
Clinical Psychologist	Indirect -via centrally based NUA Clinical Care Team – advisory.
Other –Management Support	Indirect -via centrally based NUA Care Team – advisory.

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Indirect -via centrally based NUA Clinical Care Team – advisory.
Non-Consultant Hospital Doctor	Indirect -via centrally based NUA Clinical Care Team – advisory.

Complaints

The residence had a complaints policy, which was on display in the communal areas. Residents were aware of how to make a complaint and could do so at any time by completing a complaints form. This would be forwarded to the management for review and sent to the complaints department in Nua Healthcare, which reviewed the complaint and reverted it back to the operations manager. All residents had access to advocacy services and their families and social workers had access to the policies, should they need to support a resident with a complaint. The complaints officer was responsible for addressing complaints and would advise the operations manager of same. A complaints log was maintained in the residence and weekly community meeting were held and minutes kept. There was a Suggestion Box in the residence and agenda items were brought to meetings through keyworkers.

Risk management and incidents

There was a risk management policy in the residence. All staff were required to read and sign the risk management policy and a risk management plan was in place. Risk management was discussed at team meetings and at handovers with the registered psychiatric nurse involved in any reviews. Although risk assessments were carried out for residents, they did not reflect a multi-dimensional approach. Most were functional assessments based on an Antecedent-Behaviour-Consequence (ABC) Model. Incidents were documented within an internal IT resource by the operations manager or their delegate. This would then be discussed and recorded during daily handovers by the team and escalated to the multi-disciplinary team for presentation to the weekly executive and senior management governance forum.

There was coded access to the building, both through the front and back doors. The residence's furniture was fire retardant and medication, chemicals, and sharps were stored securely in locked cupboards. Weekly car safety checks were conducted, as were weekly health and safety checks and fire audits. There was also a daily safety walk by the management, and staff training included safety and security. All fire extinguishers were in date and fire escapes were easily accessible. The residence had a first aid kit.

Financial arrangements

The residence had a policy on managing residents' finances. Charges to the residence were payable by HSE Mental Health Services by CHO area via a Service Level Arrangement Processes. Residents were supported to fully manage their finances by keyworkers and care staff in line with Nua's policy. Where finances were managed on behalf of a resident, staff involved the resident in decisions about their finances to the greatest extent possible and consistent with their safety and wellbeing. Staff ensured that all transactions by a resident involving the service user's finances were recorded and periodically independently audited, and that robust quality assurance arrangements were used to demonstrate all reasonable steps were taken to prevent financial abuse. Staff assessed the risks of financial abuse in the service and put arrangements in place to ensure that these risks were managed and followed up. Finances were audited daily by an administrator and staff on shift. At the end of the month, an administrator would undertake an overall finance audit for each resident. Residents did not contribute to a kitty or social fund. Nua healthcare funded a kitty for Sky Television, newspapers, and magazines.

Service user experience

The inspection team took available opportunities to engage informally with residents. All residents felt that their care was good, and that staff were supportive. Another resident was complimentary of the food and menu.

Areas of good practice

1. Care provided was consistent with good social care.

2. The spacious residence was well maintained with good facilities and outdoor space and garden.

3. Staff were attentive to the everyday needs of residents and motivated to learn how care could be further improved.

Areas for improvement

1. The residents would benefit if care was directed towards a committed and consistent rehabilitation and recovery philosophy. This would entail an increase in the ratio of qualified nursing staff and further access to multi-disciplinary staff to address mental health needs as well as physical, social, vocational, and psychological needs.

2. Physical restraint and locking of exit doors must not be carried out in a community residence.

3. The residence should adopt a more person-centric focus that promotes increased autonomy and choice, active participation with resident's directors of their own recovery care programme and move away from a prescriptive continuing care approach.