Glenville Crisis House

Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

Glenville Crisis House

ID Number: RES0089

24-Hour Residence – 2021 Inspection Report

Glenville Crisis House
Glenconnor Road
St. Luke's Campus
Clonmel
Co. Tipperary

Community Healthcare Organisation:
CHO5

Team Responsible:
All Carlow/Kilkenny South Tipperary Adult Mental Health Service sector teams

Total Number of Beds: 8

Total Number of Residents: 8

Inspection Team:
Mary Connellan, Lead Inspector
Sarah Moynihan

Inspection Date:
07 December 2021

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

Glenville House, known also as *The Crisis House* was an eight bedded facility for residents who required immediate support, care and understanding. It was not intensive treatment option but offered support for individuals in crisis. Residents were all under the care of a community sector team and were admitted to Glenville House for a short duration. The model of care offered admission of between 24 – 72 hours. In reality most admissions were typically over one week. At the time of inspection, seven residents had been in the Crisis House for between three and four weeks. One resident had resided in the house for a number of years.

Residence facilities and maintenance

Glenville House had opened as the Crisis House in 2012. It was deemed to be a temporary premises. Funding had been secured for a new purpose-built facility that was due for completion in 2016. At the time of inspection in December 2021, staff advised that site works on the new premises had commenced and that this was now due for completion in 2023.

The premises was a single storey bungalow styled dwelling. The entrance lobby led directly into a small sitting room with a television. Directly opposite this room was a nursing/staff office and either side of these rooms there were four single bedrooms, eight in total. The bedrooms varied in size but each contained a wash hand basin, a wardrobe, a locker and room for personal effects. Four bedrooms had been painted in the months prior to the inspection. There was a large kitchen and dining area that could be used for recreational pursuits outside of mealtimes. There was a laundry room with a washing machine and dryer for resident use.

There were five toilets in the building, three were mainly used by residents. One was in a staff area and another in a disabled bathroom and was not generally used. The disabled bathroom also contained cleaning equipment. The disabled bathroom was noted to be extremely cold and the radiator did not appear to be functioning. The inspectors found this room to be wholly unsuitable. There was a strong malodour of stale urine in one toilet. Staff reported that this was continuously present despite regular deep cleaning.

Food was cooked and transported to Glenville House from a central kitchen in Tipperary University Hospital (Tipp UH). There was a choice and variety of food provided. Dinner and supper were served at 12 midday

and 4pm respectively and while these were considered early, there was ample food stuffs available for the residents outside of these times. The kitchen was open at all times and residents were free to make light meals or snacks whenever they wished.

The residence although aged and in need of refurbishment was clean. Furniture was considered old and in need of replacement. One wardrobe was completely broken. In some rooms there appeared to be a musty smell. The curtains in a number of rooms were ill fitting and tended to fall from the hooks. This was described by staff as an ongoing issue and related to paper light curtain hooks that did not function adequately. In one bedroom the curtain was missing completely from one of the windows. In the same room there was a draught from the window. Most windows and external doors throughout the house were of poor repair and in need of replacement. Both internally and externally there was chipped and peeling paint. The nursing office was small. There was poor storage and old documents were stored in boxes in this office.

Resident profile

There were eight individuals resident in the house on the day of the inspection. One person had resided in the house for a number of years. All other residents had resided for periods of between three and four weeks. This was of longer duration than what was proposed or originally planned for admission lengths to the house. An admission timeframe of between 24 and 72 hours was documented in the Service User Information Booklet.

On the day of the inspection the residents ranged in age from mid twenty to early sixty. There was equal number of male and female residents. Residents were from a mix of the sector teams; Tipperary, Clonmel East and West, Cashel, Rehabilitation and Recovery or Psychiatry of Later Life (POLL).

Care and treatment

There was a policy on individual care planning. Each resident was under the care of their respective sector team, POLL or the Rehabilitation and Recovery team. Individual care plans were reviewed with the resident and their team weekly. A nurse from the Crisis House would attend these meetings.

The care planning meetings were usually held in the residence. Due to COVID-19, one team was holding their meeting via teleconference. One team (Clonmel West) held their meeting on the campus and not directly in the house. It was reported that in these instances the resident accompanied by the nurse may not always be seen at the arranged time and consequently may have had to return to the residence and reattend for the appointment at a later time. Staff reported to the inspectors that this was unsatisfactory for both the resident and staff.

Physical care

There was a physical care/general health policy. Residents had access to their general practitioner, if required. Staff had access to an Automated Electrical Defibrillator (AED) that had been checked weekly. There was also an emergency bag and first aid equipment.

One resident had resided in the house over six months, and a six-monthly general assessment had been completed. Residents had their own general practitioners. There was information available regarding national screening programmes. Residents also had access to other health services and general hospital services. As most of the residents' stay was of short duration, these were not usually applicable.

Therapeutic services and programmes

Each resident received a therapeutic service from their respective treating team. Programmes were not delivered directly in the house. As applicable, residents attended services and programmes outside of the house. As applicable, residents attended day centres, training centres and education facilities.

Recreational activities

There were a number of DVD's, books and board games in the residence. There was one television for eight residents. This was located in the main sitting room. There was space for individual recreational pursuits in the dining area of the kitchen.

Medication

Each resident had a medication a Medication Prescription Administration Record (MPAR). Medication was supplied by the resident's pharmacy of choice and stored on behalf of the resident in a locked medication press. Nursing staff administered all medication to the residents as prescribed.

Community engagement

The residence was situated on the campus of the former St Luke's Hospital. This was slightly outside of the town but was served by buses. As the residents came from different areas throughout the wider service and for the greater part stayed for short time in the residence, community engagement was not paramount.

Autonomy

The residents were free to come and go as they wished. Residents were requested to inform staff when they were leaving the house. The house was used for crisis intervention or acute respite purposes for a brief period. There were policies prohibiting the use of alcohol and illicit substances. There was also a no smoking policy within the residence.

Staffing

Two registered nurses were on duty day and night in the residence. There was an arrangement whereby one of the night staff, a clinical nurse specialist was on call to the accident and emergency department in Tipperary University Hospital (Tipp UH). If called to the accident and emergency department, the nurse was replaced. From time-to-time supernumerary student nurses were on a placement in the residence.

Members from four of respective treating clinical teams attended the residence to see and review the residents. These included Cashel, Clonmel East, Rehabilitation and Recovery and the Psychiatry of Later Life (POLL) teams. Residents who were under the care of Clonmel West travelled to the community clinic located on the campus to be seen and reviewed. This was deemed unsatisfactory as it was reported that frequently the time slots for the resident to be seen were changed. The resident also had to be accompanied by one of the two nurses in the approved centre for this appointment. At the time of inspection, the Tipperary sector team were having their team meetings with residents via teleconference.

As applicable health and social care professionals, i.e., occupational therapists, social workers and psychologists worked with the residents on a one-to-one basis. There was no designated occupational therapist for Glenville House, therefore, all interventions were planned on a one-to-one basis. No group work was facilitated or delivered directly in the residence.

There was one household staff daily. It was reported that frequently the household staff was redirected to a different location. It was noted that most recently on the day preceding the inspection the household staff had been rostered elsewhere. This impacted on the cleaning schedule in the residence.

Complaints

There was a complaints policy. Information about how to make a complaint was displayed in the residence. There as a local complaints log where minor complaints had been documented along with details of subsequent actions. There was a suggestion box whereby residents could give feedback and make suggestions for the residence.

Risk management and incidents

There was a policy on risk management procedures. Risk assessments had been completed on residents at admission and updated as applicable at least weekly. Staff recorded and documented incidents using the National Incident Management System (NIMS). The residence was old and in need of complete refurbishment. The windows for example were fragile and some were draughty. The building was all on the ground floor level and there were accessible fire escapes. There were fire extinguishers throughout the residence. These were due to be serviced within a month of the inspection. There was an Automated External Defibrillator (AED) and a first aid bag in the residence.

Financial arrangements

There was a policy on managing residents finances. Residents were not charged for their stay in Glenville House. Furthermore, residents did not contribute to the running of the house, and there was no general kitty or social fund. If requested there was a safe for the safe keeping of residents' monies. Residents generally managed their own monies. Large sums of money could be lodged to a residents account in the main hospital.

Service user experience

Upon arrival to the house, the inspectors briefly met with three residents. On the walkabout, the inspectors spoke casually to a further two residents. One resident chose to meet formally with the inspectors. They described the facility as extremely beneficial to them. In particular they praised the staff. They praised the food, stating dinner and tea were served and that the kitchen was open to the residents at all times.

Areas of good practice

1. Residents could come and go during their stay. There was an open-door policy and residents attended to their day-to-day routine with support from staff.

2. The kitchen and kitchen facilities were open at all times. Residents could prepare light meals to have along with the three main meals.

Areas for improvement

1. Residents under the care of the sector team Clonmel West did not have the same access to their treating team as all other residents in the house. Appointment times for a different location on the campus were given to these residents. It was reported that the resident may attend their appointment, only to find that it had been rescheduled to a later time. In these instances, the resident would be accompanied by a nurse who had their medical file. For all other sector teams the resident was seen directly in the house or via teleconference.

2. A number of the bedrooms had ill-fitting curtains. The curtain hooks were of poor quality and tended to fall off when the curtains were being closed.

3. The bedroom furniture, that is wardrobe and locker in one bedroom required replacement.

4. The residence was in need of complete refurbishment and upgrading. The inspection were informed that a new building had commenced and was due for completion in 2023.