Teach Folláine

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mental health commission

Focused Inspection
Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

Teach Folláine

ID Number: RES0283

24-Hour Residence – 2021 Focused Inspection Report

Teach Folláine
Kilcullen
Co. Kildare

Community Healthcare Organisation:
Independent

Team Responsible: NUA Healthcare

Total Number of Beds:
10

Total Number of Residents:
9

Inspection Team:
Sarah Jones, Lead Inspector

Inspection Date:
23 July 2021

Inspection Type:
Unannounced Focused Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 14 April 2022

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Summary of Findings

1. There was now an open-door policy and residents were free to come and go from the residence. All three residents interviewed reported they could leave the residence when they wished to do so and knew the code to exit the residence.
2. Three episodes of physical restraint had taken place; two in October 2020 and one in January 2021. One episode of physical restraint occurred in the community and two within the residence. No new episodes of physical restraint had taken place since the implementation of a restraint free policy and additional training provided to staff on 01st March 2021.
3. The inspector noted 50 medication incidents since October 2020. An internal audit completed in April 2021 highlighted non-compliances and highlighted residents were at a medium risk because of the findings. Management informed the inspector that all staff receive safe administration of medication management (SAMM) training 1 & 2 on induction and again if an error occurs.
4. The team informed the inspector that an advocate had been sourced for the person who was subject to the serious incident.
5. One NUA service user satisfaction survey was completed by one resident in May 2021 which highlighted several areas of concern. The Resident was provided with key working sessions on a regular basis to discuss the issues raised. The Resident has access to the service user forum and offered to make a complaint regarding any issue of concern.
6. On arrival the inspector witnessed three staff members not fully wearing masks whilst in the residence. A staff member did not have a mask on in the front office whilst in the room with two other people. This was observed from the window on entering the residence. A staff member was in the kitchen area not wearing a mask and the last staff member was walking through along the corridor. The national guidance and NUA's internals stand operating procedure at the time outlined if 2 or more persons were in a room, they would need to wear a mask. Teach Folláine had two infection control officers. COVID-19 signage was prominent throughout the residence.

Reason for the focused inspection

A focused inspection was carried out on the Friday 23rd July 2021 secondary to submitted issues of concern regarding restrictive practices and the management of incidents and complaints.

Service description

Teach Folláine began operating in June 2019. The property was formally a NUA residence for Intellectual Disability (Chapel View) and was under the remit of the Health Information and Quality Authority (HIQA). Managed by Nua Healthcare Services, it was a ten bed, two storey, community-based mental health residence. Eight bedrooms were inside the property and two apartments were attached including a small living space, bathroom, bedroom and kitchenette attached which catered for one individual each. The

services 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 front door to the property was open on arrival. Each exit door in the property had a key code system and residents were provided with the codes to the doors. A new gate was in place with a car sensor attached. This also had a key code for individuals wishing to leave the property and was reported by staff to never be locked. On the date of inspection, 8 of 9 residents had access to the door codes. Two individuals required fob access to and from their bed space.

Resident profile

There were nine residents at the time of the inspection. 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, all requiring different levels of support.

Care and treatment

Three episodes of physical restraint were noted; two in October 2020 and one in January 2021. Incident forms were completed on all occasions. Observation of the recorded episodes in the incident log identified that they related to verbal aggression/distress and physical aggression towards staff. One episode of physical restraint occurred in the community and two within the residence. First level response was described as engaging de-escalation and re-direction interventions. Staff were trained in the Management of Actual or Potential Aggression (MAPA). Holds were described as being 'medium standing holds' and of a short duration. One staff member took the lead, and a body check was undertaken by the Registered Psychiatric Nurse (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 RPN and, additionally, by the Director of Operations and the Risk Department at NUA headquarters. There had been no physical restraint in the Centre since the implementation of a restraint free policy and additional training provided to the staff team which commenced on the 1st of March 2021.

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 resident was self-medicating. The residents' medication and administration record (MAR) contained prescription and administration details. MARS 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. The inspector noted 50 medication incidents since October 2020. An internal audit completed in April 2021 highlighted non-compliances such as the MAR sheet had not been completed accurately and in line with best practice, or that staff had not adhered to procedures for the safe administration of medication, disposal and the recording of medicines in accordance with legislation and professional regulatory requirements or guidance. The audit stated medication management was not in line with the audit tool requirements and non-compliances identified posed a medium risk to residents. Management informed the inspector all staff receive safe administration of medication management (SAMM) training 1 & 2 on induction and again if an error occurs.

Risk management and incidents

Teach Folláine had two infection control officers. COVID-19 signage was prominent throughout the residence. On arrival the inspector witnessed three staff members not fully wearing masks whilst in the residence. A staff member did not have a mask on in the front office whilst in the room with two other people. This was observed from the window on entering the residence. A staff member was in the kitchen area not wearing a mask and the last staff member was walking through along the corridor. The national guidance and NUA's internals stand operating procedure at the time outlined if 2 or more persons were in a room, they would need to wear a mask. The Deputy Operational Manager and Director of Operations were informed on the day of inspection.

The inspector reviewed an internal safeguarding referral which was unable to be investigated under the national safeguarding team due to the incident occurring in the mental health services remit. Mental health services are not currently covered under the National Safeguarding Programme. NUA healthcare had a safeguarding policy and staff informed the inspector, staff are trained in safeguarding on induction.

The safeguarding referral could not be concluded. No documented safeguarding plan was made available to the inspector, however, therapeutic interventions and daily support from management and the staff team were in place for the Resident to safeguard them as per their assessed needs and risks.
The team informed the inspector an advocate had been referred for the person. The inspector was informed the individual was being supported by their multi-disciplinary team.

Service user experience

Two files were inspected. One NUA service user satisfaction survey was completed by one resident in May 2021 which highlighted several areas of concern. The document was informative and asked for feedback in several areas such as personal space, food, visitors/visiting, the COVID-19 Pandemic, activities, rights, complaints and happiness with the service and staff. The Resident was provided with key working sessions on a regular basis to discuss the issues raised. The Resident has access to the service user forum and offered to make a complaint regarding any issue of concern.

Three residents spoke with the inspector. Two residents were happy with the residence. All three residents reported they could leave the residence when they wished to do so and knew the code to exit the residence. One resident reported they were very happy with the staff and their interaction with them. One resident reported this was dependent on the staff member whilst the third resident reported staff were good but some could be “mistreating.” The resident did not wish to elaborate on this further however when the inspector asked if they were able to raise concerns with staff should they have any, the person expressed they were able to approach staff.