Ashford House (Temporary Residence – Aishling House)

ID Number: RES0101

24-Hour Residence – 2017 Inspection Report

Ashford House (Temporary Residence – Aishling House)
Co. Longford

Community Healthcare Organisation:
CHO 8

Team Responsible:
Rehabilitation and Recovery

Total Number of Beds:
8

Total Number of Residents:
7

Inspection Team:
David McGuinness, Lead Inspector
Siobhán Dinan

Inspection Date:
8 June 2017

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
20 April 2018

Contents

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

Ashford House had been under renovation since October 2016 and residents were temporarily residing in Aishling House. Aishling House was an eight-bed, two-storey residence that was formerly used by the disability service. It was situated close to the main Longford to Dublin road.

The residence was operating as a 24-hour, nurse-staffed community residence. The plan was for residents to move to Hillcrest community residence (previously renovated), which would then function as a medium support community residence.

Resident profile

The residents, five women and two men, ranged in age from 59 to 69 years; three were over age 65. All residents had ongoing mental health difficulties and had been in the residence for between 3 and 20 years. All residents' legal status under the Mental Health Act 2001 was voluntary and no resident was a ward of court. One resident had a visual impairment.

Care and treatment

At the time of inspection, residents were under the care of the rehabilitation team. The consultant psychiatrist and one non-consultant hospital doctor attended the 24-hour residence weekly. There was a policy on individual care plans (ICPs). All residents had a multi-disciplinary ICP, and these were reviewed every six months. Residents were involved in the care planning process and could attend their care plan review meeting. Residents signed their ICPs and were offered a copy of same. The clinical progress notes were well maintained and up to date. These provided a clear account of each resident's progress, care, and treatment. The clinical files showed evidence of medical, nursing, occupational therapy, and social work input. There was no evidence of input from clinical psychology. There was no psychologist on the rehabilitation team, however, this position had been advertised with the National Recruitment Service. Residents were psychiatrically reviewed every three months. Residents had ready access to a primary nurse and to other members of the rehabilitation team.

Physical care

The residence had a policy on general health. All residents had their own GP. Physical examinations were undertaken by residents' GPs annually or more frequently if needed, and these were recorded in the clinical files. Residents were provided with information about national screening programmes and were encouraged to partake in screening. They also had access to other health services through their GP such as dental care, dietetics, speech and language therapy, general hospital services, and chiropody. The rehabilitation team or GP made referrals for general health services such as physiotherapy, tests and investigations, and specialist consultations.

Therapeutic services and programmes

There was a policy on therapeutic programmes. Five residents attended the local day centre. Activities available in the residence included daily crosswords, TV, and radio. Resident-based programmes also included personal hygiene and daily living skills. Various day trips were organised each week such as shopping and coffee mornings.

Medication

There were policies on medication management. Medication was prescribed by the non-consultant hospital doctor, consultant psychiatrist, or GP. A Medication Prescription Administration Record (MPAR) system was in operation. Three local pharmacies supplied the medication. The MPARs were inspected and were in order. They contained valid prescriptions and administration details. No residents were self-medicating at the time of inspection. All medications were stored appropriately and legally.

Community engagement

Aishling House was located on the outskirts of a large town. While there was a bus service available, residents preferred to use taxis. They had access to shops, the post office, and a local hairdressers and barbers. Residents regularly attended football matches locally. A HSE-owned minibus was also available to the residence to facilitate residents' access to community activities.

Autonomy

Residents were free to come and go as they wished. They had free access to the kitchen to prepare meals or snacks if they wanted. Residents could assist with domestic activities and chores. Some residents did their own shopping, whereas others required the assistance of staff to shop for clothes and other personal items. Residents were free to determine their own bedtime. Residents did not have a key to their own bedroom.

Residence facilities and maintenance

Aishling House was a temporary residence to accommodate the residents of Ashford House while it was being refurbished. Downstairs, there were two dining areas, a sitting room, a bathroom, and a double bedroom. The double bedroom accommodated one resident. Upstairs, there were two single and three double bedrooms, a toilet, and an assisted shower. There was no privacy screening between the beds in the shared accommodation. Residents could personalise their rooms.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager	1 (14:00-21:45)	
Registered Psychiatric Nurse	1 (08:00-15:30)	1
Health Care Assistant	1 (09:00-17:00)	
Multi-Task Attendant	0	

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	On needs basis
Social Worker	On needs basis
Clinical Psychologist	0

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Once per week
Non-Consultant Hospital Doctor	Once per week

Complaints

The residence had a complaints policy, which was the service policy. *Your Service Your Say* information leaflets were on display. Residents were aware of how to make a complaint. Any complaints received were addressed by the clinical nurse manager in the first instance and escalated if required to the assistant director of nursing. No complaints log was available but no complaints had been received. There was a suggestion box for residents in the corridor of the residence. Staff informed the inspectors that community meetings were held, but no minutes of these were maintained.

Risk management and incidents

There was a risk management policy, and the residence operated in accordance with this policy. There was a defined system for reporting, managing, and investigating incidents. Individual risk assessments had been completed for all residents and were updated regularly. Incidents were recorded and managed in accordance with the National Incident Management System protocol. The residence appeared to be physically safe. All fire extinguishers were in date and were regularly checked by a qualified external contractor. A first aid kit was available.

Financial arrangements

There was a policy on managing residents' finances. Residents either held their own monies in the post office or in personal bank accounts. Residents were encouraged to manage their own monies. Some residents kept small amounts of money in a safe in the residence, which was overseen by two staff. These residents could access their money daily by request. Receipts were retained for expenditures, and all withdrawals of residents' money were signed by a staff member and countersigned by the resident. The monies and transaction records maintained in Aishling House were audited by the clinical nurse manager. The weekly charge for residents was €60, which included food and utilities. The residence did not have a communal social fund.

Service user experience

No service user expressed a desire to meet with the inspection team on an individual basis. A number of residents, who were greeted during the course of the inspection by the inspection team, expressed satisfaction with their care and treatment.

Areas of good practice

1. Residents were now under the care of the rehabilitation team.

2. The residence provided a comfortable environment for a number of long-term service users. Staff were well engaged with residents. Residents were free to come and go as they wished.

3. Residents maintained autonomy in attending their own GP and managing their own general health care appointments.

4. Multi-disciplinary care planning had been implemented.

5. The responsible consultant psychiatrist regularly attended the residence.

Areas for improvement

1. Each resident should have his or her own bedroom.

2. A log of all complaints, including actions arising, should be maintained within the residence.

3. Privacy screens should be installed between beds in shared rooms.

4. Minutes of community meetings should be maintained.