Hillcrest House

ID Number: RES0099

24-Hour Residence – 2017 Inspection Report

HIllcrest House
Co. Longford

Community Healthcare Organisation:
CHO 8

Team Responsible:
Rehab and Recovery

Total Number of Beds:
8

Total Number of Residents:
7

Inspection Team:
Siobhán Dinan, Lead Inspector
David McGuinness

Inspection Date:
9 June 2017

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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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

Hillcrest had operated as a 24-hour, nurse-staffed, high-support community residence since September 2012. Previously, it was a medium support residence. Staff did not know precisely when the residence opened as a mental health community residence but thought it was approximately 15 years ago. The function and philosophy of care was rehabilitation and recovery. Hillcrest was a two-storey, former private residence situated on the outskirts of Longford town on the main Longford to Dublin road. Staff aimed to create a homely, warm, and welcoming environment, which promoted residents' well-being. Based on the recovery model of care, staff strived to enable residents to reach their optimal level of involvement within the community. Future plans indicated that residents temporarily residing in the Aishling community residence would be moving to Hillcrest, which would then function as a medium support community residence. Residents from Hillcrest would move to the newly refurbished Ashford community residence, which would function as a high-support residence.

At the time of inspection, residents had been living in Hillcrest for many years, ranging from between 1 and 15 years.

Care and treatment

The consultant psychiatrist and one non-consultant hospital doctor attended the 24-hour residence weekly. There was a policy on individual care plans (ICPs), and all residents had an ICP. Care plans 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. Family members were also invited to attend review meetings. All ICPs showed evidence of multi-disciplinary team (MDT) input. The clinical files showed evidence of medical, nursing, occupational therapy, and social work input. There was no evidence of input from clinical psychology. No psychologist was on the rehabilitation team at time of inspection. The MDT meetings were held on a monthly basis but not in the residence. The MDT meetings were held in the rehabilitation and recovery office in St. Joseph's Hospital. The clinical nurse manager (CNM) 2 attended the monthly MDT meeting. The clinical progress notes were well maintained and up to date and provided a clear account of each resident's progress, care, and treatment. A psychiatric evaluation was documented in the file at least six-monthly. The nursing staff on-site functioned as key workers for the residents.

Physical care

There was a policy on physical health care for residents. All residents had their own GP. Residents attended the surgery themselves and did not necessarily inform or involve staff in this process. If a resident was physically ill, the GP would attend the community residence or the MyDoc service would be called in the evenings and during weekends. Physical examinations were undertaken by residents' GPs annually or more frequently if needed, and these were recorded in the clinical files. Information on national screening programmes was provided to residents by their GPs. At the time of inspection, residents were receiving appropriate screening programmes. Residents had access to other health services through their GP such as dental care, dietetics, speech and language therapy, general hospital services, and chiropody. Residents' GPs made referrals for general health services such as physiotherapy, tests and investigations, and specialist consults. There was an Automated External Defibrillator and a first aid box in both nursing offices.

Therapeutic services and programmes

There was a policy on therapeutic programmes. Activities delivered in the residence included board games, daily crosswords, bingo, TV, and radio. Various outings were organised each week such as shopping and trips to cafés, football matches, and the local theatre. Residents attended sessional activities off-site in the local day centre. Activities in the day centre included cookery, relaxation, a Boccia tournament, music, Pilates, and arts and crafts. GROW (World Community Mental Health Movement in Ireland) meetings were also held in the day centre weekly.

Medication

There was a policy on medication management. The consultant psychiatrist and the non-consultant hospital doctor prescribed medication. Three local pharmacies supplied the medication. The MPARs were inspected and were in order. The MPARs contained valid prescriptions and administration details. No residents were self-medicating. All medications were stored appropriately and legally. Medicines were stored in a locked medicine trolley in a locked room.

Community engagement

The location of Hillcrest facilitated community engagement. Residents could access Longford town easily for social outings. There was a GAA pitch, shopping centre, local park, library, church, and restaurants nearby. There was a local hairdressers and barbers that were also used by residents. Residents shopped in local supermarkets and some residents visited bookies nearby. The local theatre staged music and drama productions frequently, and some residents attended regularly. Residents regularly attended football matches. The local catholic parish was St. Mel's Cathedral, where some residents attended mass. Residents had access to rail and bus services. A minibus was provided by the residence to access community activities. The Legion of Mary visited the residence once a week. The Mental Health Association organised an annual Christmas dinner and raffle with spot prizes for residents and their families. An advocacy group was also available to residents by request. Staff told inspectors that some residents went on an annual holidays with their families.

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 wished. Residents did not shop for or cook meals. Breakfast was prepared between 8am and 10am, dinner was prepared for 12.30pm, tea was prepared for 5pm, and supper was offered at 8pm. A daily menu was displayed in the dining room. Residents had input into the weekly shopping list, and shopping was delivered to the residence. The kitchen was locked at 10pm, but residents could request snacks from the staff and this was facilitated. Residents were observed going out and about to the local shops and amenities. One resident was working in a local garage. Residents were free to determine their own bedtimes. Residents did not have a key to their own bedroom. Bedrooms could be locked from the inside for privacy and could also be over-ridden by staff if deemed necessary. Residents were responsible for their own laundry and there was a laundry schedule to ensure everyone had time to use the facilities. Residents also tidied their own rooms and gardened. Residents were free to receive visitors at any time. The residents told the inspection team that the meals were very good and that they had input into the menus.

Residence facilities and maintenance

Hillcrest was a two-storey former private residence. The first floor consisted of two sitting rooms, one of which was used as an activities room, an assisted bathroom/shower room, a large kitchen/dining room, a linen cupboard, a laundry room, and a nurses' office. The second floor consisted of five bedrooms (three double bedrooms and two single bedrooms), an assisted bathroom/shower room and a clinic room/nurses' office. One bedroom was for respite and was unoccupied at the time of inspection. The double bedrooms afforded little privacy to residents who were sharing. There was a fire escape in the top bedroom. All of the rooms were homely, and residents could personalise their rooms. Residents' artwork and photographs were displayed throughout.

The residence had been newly renovated. The renovation consisted of new flooring, a new heating system, new improved insulation, new bathrooms, a new kitchen, and new furniture and furnishings throughout the residence. The exterior and interior of the premises had been newly painted. A new gazebo had also been installed in the back garden.

Staffing

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	As required
Clinical Psychologist	No input

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Weekly
Non-Consultant Hospital Doctor	Weekly

Complaints

There was a policy on complaints. The HSE's *Your Service, Your Say,* complaints procedure was posted up in the sitting room of the residence. Residents interviewed stated that they knew how to make a complaint. The process for making informal complaints within the residence was verbally to any of the staff. The clinical nurse manager was responsible for responding to all complaints made within Hillcrest and for escalating complaints up to the assistant director of nursing, where indicated. There was no complaints log; however, some complaints were logged in the community meeting minutes. These provided an account of the complaint, the actions taken, and the outcome. Community meetings were held once a month. Minutes of these meetings were kept. There was a suggestion box for resident use in the hall of the residence.

Risk management and incidents

There was a risk management policy. There was also a safety statement and a risk register. The residence operated in accordance with the policy. Risk assessments were carried out for residents on admission on an ongoing basis. The risk assessments for all residents had been updated regularly. Incidents were recorded and managed in accordance with the National Incident Management System protocol. The incident logs were inspected. The residence appeared to be physically safe. All fire extinguishers were in date and fire escapes were easily accessible. There were first aid kits available in the kitchen and in both offices.

Financial arrangements

There was a policy on managing residents' finances. All residents had their own bank accounts. Residents were encouraged to manage their own monies and to budget and save regularly. Where a resident required nursing staff assistance with personal finances, this was written in their ICP and staff went with residents to the bank to withdraw their money every week. Residents requiring nursing staff assistance with personal finances kept their monies locked in individual drawers in the office. These residents could access their money daily by request. Receipts were retained for expenditures, and every time a resident withdrew money, this was signed out by a staff member and countersigned by the resident. The monies and records maintained in Hillcrest were audited by the clinical nurse manager monthly. The weekly charge for residents was €60. Food and utilities were included in this charge.

Service user experience

The inspection team greeted residents and explained the purpose of the inspection. Two residents spoke individually with the inspectors. Each considered the residence to be warm and comfortable and were satisfied with their care and treatment. The residents told the inspection team that the meals were very good and that they had input into the menus.

Areas of good practice

1. The quality and care of residents was excellent.
2. Residents maintained autonomy in terms of attending their own GP and managing their own general health care appointments.
3. Multi-disciplinary care planning had been implemented.
4. The responsible consultant psychiatrist regularly attended the residence.
5. Extensive refurbishment had taken place.

Areas for improvement

1. All residents should have their own bedroom.