The Willows

ID Number: RES0078

24-Hour Residence – 2017 Inspection Report

The Willows
Riverchapel
Gorey
Co. Wexford

Community Healthcare Organisation:
CHO 5

Team Responsible:
Rehabilitation

Total Number of Beds:
9

Total Number of Residents:
7

Inspection Team:
Dr Ann Marie Murray, MCRN 363031, Lead Inspector

Inspection Date:
16 August 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

The Willows, a nine-bed, 24-hour, nurse-staffed residence, was located in Gorey, Co. Wexford. The Willows was previously called Ardamine House. The residence was owned by the HSE, Community Healthcare Organisation (CHO) 5. The house, which opened in 1980s, was set back from the main road and was surrounded by a sizeable garden. The house was not purpose built and had originally been used in the 1960s and 70s as a holiday home for residents of St. Senan's Hospital.

The Willows was a two-storey house consisting of two interconnecting adjoining houses. Many of the residents were transferred to the Willows when St. Senan's hospital closed. At the time of inspection, it provided accommodation for seven residents in single-occupancy bedrooms. The residence provided high support, 24-hour continuing care for the resident group. There were no plans in place to renovate the building to make it more accessible to the ageing population of residents.

Resident profile

Residents ranged in age from 65 to 80 years. At the time of inspection, three female and four male residents were accommodated in The Willows. The duration of stay ranged from 3 to 30 years. All residents were of a voluntary status, and there were no wards of court. A number of residents had mobility issues, and there was a stair lift in place to help them access the upper floor, however this was not always utilised by residents.

Care and treatment

The Willows had a policy with regard to individual care plans (ICPs). All residents had an ICP, but these were not always multi-disciplinary as the occupational therapist and social worker did not always attend the ICP meetings. There was a key worker system in place involving four registered psychiatric nurses. Residents attended ICP meetings, which were held annually within the residence, and they reviewed their ICPs with their key worker. Residents had not received a psychiatric evaluation every six months.

Residents had access to a rehabilitation team, including occupational therapy and social work. At the time of inspection, there had been no rehabilitation psychologist for three years because of recruitment issues.

Physical care

The Willows had a policy in place in relation to physical care/general health. All residents had access to a local GP, however GPs did not complete routine six monthly examinations of residents. Routine physical examinations were completed by a psychiatric registrar on a six-monthly basis. Information about screening programmes was displayed in the residence, and residents had access to appropriate screening programmes, including retinal and bowel screening. Other health care services were available to residents in the general hospitals in Wexford and Waterford, and a primary care centre in Gorey. Physiotherapy was available in St. John's Hospital in Enniscorthy, and dietetics was available through primary care. Speech and language therapy were available in Wexford General Hospital.

Therapeutic services and programmes

The Willows had a policy in relation to the provision of therapeutic programmes. Residents had no access to therapeutic programmes within the residence, although there were plans to introduce some nurse-delivered programmes. On the day of inspection, just one registered psychiatric nurse (RPN) was rostered with a multi-task assistant (MTA). There was a high demand on the staff to address residents basic care needs, such as showering and dressing. This left very limited time for staff to engage with residents in meaningful rehabilitative activities. Several residents attended therapeutic programmes off-site, in St. Aidan's Day Care Centre in Gorey, three days' a week. The day centre provided a range of therapeutic activities for older people in the community including Sonas therapy and reminiscence therapy. It also provided bingo and other recreational activities and facilitated day trips and outings.

Medication

The Willows had a policy in relation to medication management. Medication was prescribed by the residents' GP, the consultant psychiatrist, the psychiatric registrar, or the outpatient department doctor. A Medication Prescription Administration Record (MPAR) system was in operation, but a number of omissions were identified on inspection. In three MPARs, the Medical Council Registration Number (MCRN) of the prescribing physician was not recorded. In one MPAR, the signature of the prescribing physician was not included. The allergy section had not been completed in any of the residents' MPARs.

Medicines were supplied by a pharmacy in Gorey. Medications were checked on arrival by nursing staff and stored in a locked cupboard, with the exception of two medications, which were observed in an unlocked drawer. The medication fridge was stained and dirty, and it was inappropriately used for the storage of food

items and water. The temperature of the fridge was not being monitored routinely. Residents did not manage their own medication, and no resident was self-medicating.

Community engagement

The location of the Willows facilitated community engagement. The residence was close to shops, the local church, and the village. Residents liked to go shopping, and they attended mass on Sundays. They also went to the local hairdressers and the bank and went into town for coffee. Residents had access to public transport, and a seven-seater people carrier was available for transporting them to activities. A musician visited the Willows once a month to play for residents, and a priest attended monthly. A local councillor visited at Christmas time.

Autonomy

Residents could come and go from the Willows as they wished.

Not all residents had their own keys to the front door because of identified risks. Residents did not appear to have free access to the kitchen area, although some were able to make tea for themselves. No facilities were available in the kitchen to support residents to perform tasks to their level of capacity.

Residents were free to determine their own bedtimes. Where appropriate, residents had keys to their own bedrooms. Some of the residents assisted with domestic chores such as shopping.

Residents were free to receive visitors at any time.

Residence facilities and maintenance

The Willows was a two-storey building in the village of Riverchapel, near Gorey. The facility was not purpose-built but developed by combining two houses. There was a sign at the entrance.

Residents had access to a large back garden area, which was overgrown and in need of attention. In addition, there were steep concrete steps in the back garden, which had been recognised as a potential safety risk for residents. The garden also featured a decking area, which had not been treated and was no longer used. The garden furniture was rusty and unused. There was an outside toilet, which was dirty and malodourous. There was also a separate building containing gym equipment and a sofa that was no longer in use. There was a polytunnel, which had previously been used to grow produce but had become overgrown because nobody was available to maintain it.

Residents were accommodated in their own rooms. There were seven single rooms and two twin rooms, which were single occupancy. One of the bedrooms was on the ground floor. All of the bedrooms had a washbasin. The rooms were attractive and personalised and had adequate storage for personal effects. There was a large crack in the mirror of the downstairs bedroom.

Many of the residents were observed to have mobility issues and the stairs presented as a potential challenge to these residents. There was a stair lift but during the inspection, residents were observed to not utilise this. There was a sharp turn at the bottom of the stairs. One resident was observed to fall down the stairs on the day of inspection. Further information in relation to fire safety and evacuation procedures was requested after the inspection, however, this was not provided.

There was an adequate number of bathrooms for residents. The accessible bathroom upstairs did not have adequate space to assist residents when toileting and showering. Rust was observed in the radiator in one bathroom and there was rust on the handrail in the accessible bathroom downstairs.

There was a kitchen area and a dining room with adequate seating for residents. The fridge temperatures were not being monitored consistently. The sitting room was large and bright, with two televisions. There was a utility room with a washer/drier. The washing machine was broken on the day of inspection, and a new one had been ordered.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager (CNM)	0-1	0
Registered Psychiatric Nurse (RPN)	0-1	1
Health Care Assistant (HCA)	0	0
Multi-Task Attendant (MTA)	1-2	0

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	Annually and as required
Social Worker	Annually and as required
Clinical Psychologist	0

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	Annually and as required
Non-Consultant Hospital Doctor	Annually and as required

Three days a week there was only one RPN rostered. On the day of inspection there was just on RPN on duty. The inspector observed a high demand on the resource of the RPN. Nursing management staff reported the aim was to roster two RPNs if possible. Nursing staff reported that they did not have time to have a staff meeting. Three days a week there were two MTAs rostered. On the other four days, there was just one MTA rostered. On the day of inspection, there was one MTA on duty.

Staff had received training in Basic Life Support and they were up to date with fire safety training. Staff had not been trained in recovery principles. At the time of inspection, staff were awaiting training in control and restraint.

Complaints

The Willows had a complaints policy and a nominated complaints officer. It used the HSE's "Your Service Your Say" complaints process, and maintained a log of complaints. Residents were informed of how to make complaints, and they had access to a suggestion box. Minor complaints were addressed locally or, where necessary, escalated to the Clinical Nurse Manager 2. Monthly community meetings were held in the residence, and minutes of these were maintained.

Risk management and incidents

The Willows had a risk management policy, which was implemented throughout the residence. Risk assessments were completed for residents, and risk management was addressed as part of the ICP process.

Incidents were documented and reported using the National Incident Management System. The main risk for residents was a risk of falls, particularly in relation to the stairs and the fact that there was just one downstairs bedroom. The fire extinguishers were regularly serviced and in date. A record of fire drills was maintained. Fire exits, located on the ground floor, were not easily accessible to residents with poor mobility who were accommodated in bedrooms upstairs. First aid supplies were available in the nursing office.

Financial arrangements

The residence had a policy in relation to managing residents' finances. The weekly charge for residents was €90, which covered accommodation, food, and utilities. Residents had bank or post office accounts and, where necessary, were accompanied by staff when they wanted to withdraw money. Residents' finances were audited externally on a regular basis. Staff were currently setting up bank accounts for all residents. A social fund that had been in place had been stopped.

Service user experience

A number of service users were greeted during the inspection. All spoke positively about their experience of The Willows.

Areas of good practice

1. The residents were involved and engaged in the local community where possible.
2. Staff were currently setting up bank accounts for all residents.
3. The entrance garden to the house was well maintained and there was clear signage.
4. The residents and staff held monthly community meetings and minutes were kept of these.
5. The residents' bedrooms were attractively decorated with personal touches.

Areas for improvement

1. The premises, with all but one of the bedrooms upstairs, did not reflect the changing needs of residents in relation to their age and mobility. Consideration should be given to the planning of the long term care of this resident profile.

2. The service should review the current risks associated with accommodating residents with difficulty mobilising in upstairs bedrooms.

3. The rostering of just one RPN on duty three days a week placed a high demand on staff with limited time left for staff to engage in meaningful rehabilitative activities with residents.

4. There were a number of omissions in the MPARs and issues with the storage of medication. Training and audit are required in this area.

5. Kitchen fridge temperatures should be recorded.

6. The assisted bathroom upstairs was not of adequate size.

7. The rear garden had fallen into disrepair and was in need of maintenance.

8. Maintenance issues such as the cracked mirror and the rust in the bathrooms should be reported to and resolved by maintenance.

9. There was a lack of MDT input into ICPs and the care and treatment of the residents. The psychology post was vacant for three years.