Ashville House

ID Number: RES0042

24-Hour Residence – 2018 Inspection Report

Ashville House
Newtown
Ballinasloe

Community Healthcare Organisation:
CHO 2

Team Responsible:
Intellectual Disability

Total Number of Beds:
6

Total Number of Residents:
5

Inspection Team:
Martin McMenamin

Inspection Date:
29 January 2018

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

Ashville House was a two-storey building located 5 kilometres north of Ballinasloe town in Newtown, Co. Galway. It was a rented property. Ashville House's lease end date was approaching at the time of the inspection. There were five bedrooms with six beds in total. There were five residents at the time of the inspection.

The house was owned and operated by the HSE as a mental health care facility for people with a dual diagnosis of an intellectual disability and a mental illness or mental disorder. It functioned as a high support hostel.

Residents care and treatment was provided under the clinical direction of a consultant psychiatrist. The intellectual disability team were responsible for residents' care. The future plans for the residence was for referrals to be made to the disability service in consideration of a more appropriate care setting.

Residence facilities and maintenance

Ashville House was a two-storey building, set on a half-acre site in a rural setting. Accommodation comprised one double bedroom, four single bedrooms, a living room, a dining room and kitchen. One bedroom and the living room was situated on the ground floor opposite an open plan dining room and kitchen. Four bedrooms were situated upstairs. There were no privacy screens/partitions in shared bedrooms.

The landlord of the property looked after the internal maintenance of the residence, including painting. The HSE was responsible for plumbing and electrical work in Ashville House. At the time of the inspection, the external appearance of the premises was unsightly; a bin was knocked over and created a litter of refuse paper. The residence kept chickens and there was extensive fouling directly outside the patio door, external to the building. The patio door led into the kitchen.

The internal and external of the Ashville House required painting. There had been no recent renovations or refurbishments. In relation to future plans for the residence, the landlord may sell it but this had not been officially announced.

Resident profile

There were five residents in Ashville House at the time of the inspection. All residents were male, ranging in age from their mid-fifties to late sixties. Four residents were voluntary and one resident was a ward of court. There were no residents with a physical disability. All residents were long-term service users, with continuing mental health care needs.

Care and treatment

There was a policy on individual care planning. All residents had an individual care plan (ICP). A key worker was assigned to each resident.

The ICPs had multi-disciplinary team (MDT) input in the development aspect of ICPs. Only nursing staff were assigned documented actions in relation to actual interventions identified in residents' ICPs. Apart from being informed of their ICPs, residents did not have any input into their ICPs.

The ICPs were reviewed on a six-monthly basis. Review meetings were attended by the nursing staff, and residents were welcome to attend. The ICP review meetings took place in St. Joseph's Day Centre in Ballinasloe and not in the residence. Six-monthly psychiatric evaluations were documented in all ICPs inspected.

Physical care

There was a policy on physical care and general health. All residents were registered with a local GP. All residents received a six-monthly physical examination by their GP which will extend to 12 monthly in the future. Residents received information and had access to appropriate national screening programmes. They also had access by referral to other health services, where required through community services, such as physiotherapy, dentistry, dietetics, and speech and language therapy and general hospital services.

Therapeutic services and programmes

There was a policy on therapeutic programmes. Nursing and other care staff lead therapeutic services and programmes, which were delivered on-site in Ashville House. In addition, residents attended therapeutic programmes off-site in in a day centre.

Recreational activities

There were recreational activities available in Ashville House. Ashville House had a small amount of horticulture activities. One resident looked after a pony and assisted with mucking out the pony's stable on a weekly basis.

Ashville house had a TV for residents' use. Residents went on a daily outing by bus to places such as Knock or Athlone. Some residents attended the Day Centre for art activities.

Medication

There was a policy on medication management. There was a Medication Prescription and Administration Record (MPAR) for each resident, which contained valid prescription and administration details. The consultant psychiatrist and general practitioner prescribed medication for the residents.

No resident was self-medicating because all residents required assistance and supervision with medications. Medications were stored appropriately and legally in a separate locked cabinet in Ashville House. A local pharmacy supplied the medication.

Community engagement

The location of the residence facilitated community engagement. Ashville House was situated in a country setting with farms and other houses nearby. There was local transport for residents to use to access shops and community activities, but they usually travelled by the bus which was owned by Ashville House.

Residents attended community activities such as bowling, football games, local concerts, and eating out once a week. There was community in-reach into the residence, and occasional music sessions took place in the residence. The music sessions were delivered by a relative of a service user.

Autonomy

Each resident needed assistance in using the kitchen to prepare meals or snacks. Residents were free to determine their own bedtime, and they did not have a key to their own bedroom. Residents assisted with domestic activities such as using the dishwasher and sweeping the residence. They could receive visitors at any time. Residents were not free to leave the residence as they wished; they required nursing staff supervision to do this at all times.

Staffing

Staff training records indicated that staff had received training in Basic Life Support, fire safety, and the management of violence and aggression. Staff were not specifically trained in the philosophy of recovery.

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

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	As required
Social Worker	As required
Clinical Psychologist	As required
Other – Speech and Language Therapist	As Required

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

Complaints

There was a complaints policy. The complaints process was displayed in a diagram format for residents' relatives to interpret and understand. Residents had communication challenges, but familiar staff were able to assist in articulating residents' views and their complaints. Complaints were made to the nurse in charge. The clinical nurse manager 2 was responsible for addressing complaints. There was a complaints log. There were not any community meetings. Residents were kept informed of events and programmes daily. There was not a suggestion box.

Risk management and incidents

There was a risk management policy in place. The policy was implemented in the residence. Risk assessments were completed for each resident. Where applicable, the clinical manager 2 completed incident management forms and reported incidents to line manager.

The residence was physically safe and secure. There was a fire alarm installed and fire extinguishers were in date. Fire escapes were easily accessible. It was unclear to inspectors when fire extinguishers were last serviced. There was a first aid kit.

Financial arrangements

There was a policy on managing residents' finances. All residents had a credit union or post office account. Procedures were in place for staff handing residents' money, this was managed by nursing staff. Nursing staff accompanied residents to the post office and credit union.

Residents accessed their money by asking staff. Each resident contributed a weekly charge of between 100-200 euro for food and utilities. This was receipted and checked by the clinical nurse manager 2 monthly. It was unclear whether residents had consented to this practice. There were plans to move resident finances to a central control and allocate personal funds.

Service user experience

Residents had communication challenges, but familiar staff were able to assist in articulating residents' views. The presence of the inspector upset the dynamic of the residence for some of the residents, thus engagement was minimised.

Areas of good practice

1. The individual needs of each resident were provided for within an individual care plan.

2. Each resident's general health needs were maintained.

Areas for improvement

1. The house should be fully repainted internally and externally.

2. Clarification should be provided regarding the future plans for the residents and/or continuance of the existing lease.

3. More fence controls should be applied to keep chickens away from the immediate environment of the house to prevent fouling near entrance ways.