### 2017 Approved Centre Inspection Report (Mental Health Act 2001)

**Selskar House, Farnogue Residential Healthcare Unit**

**ID Number:** AC0092

**2017 COMPLIANCE RATINGS**

<table>
<thead>
<tr>
<th>Regulations</th>
<th>Rules and Part 4 of the Mental Health Act 2001</th>
<th>Codes of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Compliant</td>
<td>1 Non-compliant</td>
<td>1 Non-compliant</td>
</tr>
<tr>
<td>2 Non-compliant</td>
<td>1 Non-compliant</td>
<td>1 Non-compliant</td>
</tr>
</tbody>
</table>

**Inspection Team:**
- Carol Brennan-Forsyth, Lead Inspector
- David McGuinness
- Leon Donovan

**Dates:**
- **Inspection: 8 – 11 August 2017**
- **Previous Inspection: 18 – 20 October 2016**

**The Inspector of Mental Health Services:**
- Dr Susan Finnerty MCRN009711

**Approved Centre Type:** Psychiatry of Later Life

**Most Recent Registration Date:** 2 May 2016

**Conditions Attached:** None

**Registered Proprietor:** HSE

**Registered Proprietor Nominee:**
- Mr David Heffernan, General Manager,
  CHO 5 Mental Health Services

**Date of Publication:** 14 December 2017

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  CHO 5 Mental Health Services

**Date of Publication:** 14 December 2017
RATINGS SUMMARY 2015 – 2017

Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2015 – 2017
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1.0 Introduction to the Inspection Process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to “visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate”.

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.
2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated Judgement Support Framework, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

Safety in the approved centre

The approved centre had written policies relating to health and safety and risk management. There was a designated risk manager. Two identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of health care services. There was no evidence that food safety audits had been periodically completed. There were appropriate facilities for the refrigeration, storage, cooking, and serving of food. Hygiene was maintained to support food safety requirements, and catering areas and associated equipment were appropriately cleaned. There were safe practices for the ordering, prescribing, storage and administration of medication. Not all health care professionals were up to date with their training in fire safety, Basic Life Support, the management of aggression and violence, and the Mental Health Act 2001.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.
Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan, and the therapeutic services and programmes provided were appropriate and met the assessed needs of residents, as documented in their individual care plans. A GP attended the approved centre every day and residents received general health care interventions appropriate to their needs. Records were secure, up to date, and in good order.

For residents with special dietary needs, an evidence-based nutritional assessment tool was not routinely used. End of life care was appropriate to the residents’ physical, emotional, social, psychological, and spiritual needs. A single room was provided to residents at end of life to assure their privacy and dignity.

Mechanical restraint in the form of lap belts was used in the case of six residents. None of the files inspected documented whether less restrictive alternatives had been implemented without success before the use of mechanical restraint, and five files did not reference the situation in which mechanical restraint was being applied. There were a number of deficits in the admission, transfer, and discharge processes, including a lack of a discharge plan.

Respect for residents’ privacy and dignity

Residents were supported to keep and wear their personal clothing, and adequate storage space was provided for clothing. Residents were also allocated lockers in which to secure personal-effects. Residents’ clothes were observed to be clean and appropriate to their needs. Privacy for residents was maintained throughout the approved centre.

Responsiveness to residents’ needs

Residents were provided with a variety of wholesome and nutritious food choices. They had access to appropriate recreational activities, including movies, TV, painting, bingo, jigsaws, puzzles, music, and hand massage. Nursing staff delivered recreational activities at the weekends. There was a multi-faith church in the approved centre, and residents had access to multi-faith chaplains. There were no restrictions on resident communication and no restrictions on residents’ rights to receive visitors. Information about the approved centre was given to residents and/or their representatives at admission in the form of a resident information booklet. Information relating to diagnosis and medication information was available in the form of a booklet.
The approved centre was comfortably heated and ventilated, and communal areas were adequately lit to facilitate reading and other activities. Sufficient spaces were provided for residents to move about, including three outdoor areas and it was in a good state of repair. Bedrooms were appropriately sized to address residents’ needs, and furnishings throughout the approved centre supported residents’ independence and comfort. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively.

**AREAS REFERRED TO**

Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

**Governance of the approved centre**

The approved centre was governed by Wexford/Waterford Mental Health Services. It was part of Community Healthcare Organisation (CHO) 5, which included Wexford/Waterford and South Tipperary, Carlow and Kilkenny Mental Health Services. The Wexford and Waterford services shared the same governance structures and had adopted the same generic policies and procedures where appropriate.

The consultant psychiatrist in Selskar House chaired a business meeting once a month. Agenda items included maintenance of the approved centre, corrective actions, and challenges for the approved centre. Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. A policy group within the CHO met regularly to develop and review policies. Operating policies and procedures were communicated to all relevant staff, and all operating policies and procedures required by the regulations had been reviewed within three years.

**AREAS REFERRED TO**

Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. There was a new whiteboard in the nurses’ office, which monitored the residents’ care and treatment at a glance. The idea was to ensure that assessment time frames were adhered to.

2. The introduction of the Sonas® programme to the approved centre. This is a therapeutic communication activity primarily for older people, which focuses on sensory stimulation, in the belief that the senses are the gateways to communication.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

Selskar House was situated on the Old Hospital Road, behind Wexford General Hospital. The approved centre was built in 2013, and Selskar House occupied the ground floor of the modern, purpose-built facility. The upper floor was occupied by another facility (Abbeygale Ward), which provided care for the elderly. Some facilities within the building were shared between the two centres. Selskar House accommodated 20 residents in single rooms with en suite bathroom facilities. The unit was operating at full capacity at the time of inspection. There were no involuntary patients, none of the residents were on approved leave, and there were no wards of court.

The approved centre was square in shape, and it was spacious and bright. There was a spacious television and sitting room and a small resident dining area. There were two nursing stations and a clinical room. There was a suitable space for recreational activities at an unused nurses’ station. This space was appropriate to the needs of the residents.

There was a small, well-maintained internal courtyard garden, which the residents had access to. There was also a larger external garden to the rear of the building.

The resident profile on the first day of inspection was as follows:

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>20</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>20</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>19</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

4.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.
4.4 Governance

The approved centre was governed by Wexford/Waterford Mental Health Services. It was part of Community Healthcare Organisation (CHO) 5, which included Wexford/Waterford and South Tipperary, Carlow and Kilkenny Mental Health Services. The Wexford and Waterford services shared the same governance structures and had adopted the same generic policies and procedures where appropriate.

The consultant psychiatrist in Selskar House chaired a business meeting once a month. Agenda items included maintenance of the approved centre, corrective actions, and challenges for the approved centre. Minutes of the monthly executive management team meetings were available to the inspection team. The minutes included discussions in relation to budget and finance, capital development, and priority staffing posts. The minutes of monthly Quality and Safety Executive Committee meetings included service user involvement, the Mental Health Commission, complaints, health and safety, audits, and policies.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 18 – 20 October 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>

5.2 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2016 and 2015:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.

5.3 Areas of compliance rated Excellent on this inspection

No areas of compliance were rated excellent on this inspection.
6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents and families to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents and families to talk to the inspection team.
- Set times and a private room were available to talk to residents and families.
- In order to facilitate residents and families who were reluctant to talk directly with the inspection team, residents and families were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents’ feedback about the approved centre.

The inspection team did not meet with any service users during the time of inspection, nor did it receive any feedback with regard to Selskar House from the IAN.

7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

- Area Director of Nursing
- Consultant Psychiatrist of Old Age

The following individuals were unable to meet the inspection team:

- Principal Psychologist
- Principal Social Worker
- Occupational Therapist

Heads of discipline from medical and nursing provided an overview of the governance within their respective departments. The consultant psychiatrist of old age was based in the approved centre and was on-site most days. The area director of nursing visited the approved centre monthly. Clear lines of responsibility were evident in both departments, with heads of discipline attending regular meetings with staff and both departments providing supervision to their staff. The operational risks identified were maintaining safe levels of staff and responding to the high demand for beds in the area.
8.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Clinical Director
- Area Director of Nursing
- Consultant Psychiatrist
- Registered Proprietor
- Hospital Manager
- Assistant Director of Nursing
- Clinical Placement Coordinator
- Clinical Nurse Manager 2

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Discussion took place around transfer of residents, the use of generic policies, and the use of resident identification in Selskar House.

It was disappointing that health and social care managers were unable to meet with the inspection team, either individually or at the feedback meeting.
9.0 Inspection Findings – Regulations

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
Regulation 4: Identification of Residents

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

INSPECTION FINDINGS

Processes: The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to the identification of residents, which was last reviewed in July 2015. It included a process for the identification of residents with the same or a similar name. It did not address any of the other requirements of the Judgement Support Framework:

- The roles and responsibilities in relation to the identification of residents.
- The required use of two appropriate resident identifiers prior to the administration of medications, the undertaking of medical investigations, or the provision of other services.
- The required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had not been undertaken to ensure that clinical files contained appropriate resident identifiers. Analysis had not been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: At least two of the following resident identifiers were used in the approved centre: photograph, name, date of birth, and ID number. The person-specific identifiers were appropriate to residents’ communication abilities, the resident group profile, and individual residents’ needs. Two identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of health care services. An appropriate identifier was used before the provision of therapeutic services and programmes. A sticker system was in place to alert staff to the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident’s individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was last reviewed in April 2015. It included requirements of the Judgement Support Framework, with the exception of the process for monitoring food and water intake.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had been undertaken by the catering manager in St. John’s Community Hospital in Enniscorthy to ensure that residents of the approved centre received wholesome and nutritious food in accordance with their needs. Analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Food was prepared and cooked off-site, in St. John’s Community Hospital, and delivered to the approved centre in hot trolleys. The hospital’s dietitian analysed the approved centre’s menus to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food choices. There was a four-week menu cycle, with three meal choices every day. A number of residents had been prescribed modified consistency diets, and their meals were presented in an appealing manner. Hot meals were served daily, and residents had regular access to hot and cold drinks. There was a water dispenser in the dining room, supplying residents with safe, fresh drinking water.

For residents with special dietary needs, an evidence-based nutritional assessment tool was not routinely used. Weight charts were implemented, monitored, and acted upon monthly. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. The needs of residents identified as having special nutritional requirements were regularly reviewed by the dietitian. The GP or nurse referred residents to the diabetic service in Wexford General Hospital, as required. Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. At the time of the inspection, four residents had recently been assessed by a speech and language therapist.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 6: Food Safety

(1) The registered proprietor shall ensure:
   (a) the provision of suitable and sufficient catering equipment, crockery and cutlery
   (b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
   (c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:
   (a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
   (b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
   (c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2016. It included requirements of the Judgement Support Framework, with the exception of a process for managing catering and food safety equipment.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP) or in food safety and hygiene.

Monitoring: There was no evidence that food safety audits had been periodically completed. Food temperatures were in line with food safety recommendations, and a temperature log sheet was maintained and monitored. Analysis had not been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided specifically for catering services, and there was suitable and sufficient catering equipment. There were appropriate facilities for the refrigeration, storage, cooking, and serving of food. Hygiene was maintained to support food safety requirements, and catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 7: Clothing

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Processes: The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to clothing, which was last reviewed in July 2015. It addressed requirements of the Judgement Support Framework, with the exception of the responsibility of the approved centre to provide clothing for residents, where necessary, with consideration of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices.

Training and Education: Relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes in relation to residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of resident clothing was not monitored. At the time of the inspection, no residents were wearing night attire during the day.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, and adequate storage space was provided for the clothing. Residents’ clothes were observed to be clean and appropriate to their needs. Multi-task assistants or family members laundered residents’ clothes.

An emergency supply of clothing was available, but there was no supply of emergency underwear. Staff had access to petty cash to purchase emergency clothing if required. During the inspection, all residents were wearing day clothes. All residents had an adequate supply of individualised clothing.

The approved centre was non-compliant with this regulation because no emergency supply of underwear was available, 7(1).
Regulation 8: Residents’ Personal Property and Possessions

(1) For the purpose of this regulation "personal property and possessions” means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents’ personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident’s personal property and possessions and is available to the resident in accordance with the approved centre’s written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident’s individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident’s individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

Processes: The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to residents’ personal property and possessions, which was last reviewed in July 2015. It addressed requirements of the Judgement Support Framework, with the exception of the following:

- The communications with the resident and their representatives regarding the resident’s entitlement to being personal property and possessions into the approved centre at admission and on an ongoing basis.
- The process for giving residents access to and control over their personal property and possessions, unless this posed a danger to the resident or others, as indicated by an individual risk assessment and the resident individual care plan (ICP).

Training and Education: Relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to residents’ property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored. Documented analysis had been completed to identify opportunities for improving the processes around residents’ personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their ICPs. Residents’ families were asked to manage money, where possible. Otherwise money was lodged in an account, from which small amounts could be withdrawn by request. Residents were allocated lockers in which to secure personal-effects.

Secure facilities were available in the approved centre for the storage of small amounts of money. Valuables could be managed by residents in their rooms, which were locked during the day.
A signed property checklist was maintained, detailing each resident’s personal property and possessions. These were retained in residents’ files, separately from their ICPs. Where any money belonging to the resident was handled by staff, signed records were retained.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes pillar.
Regulation 9: Recreational Activities

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in August 2015. The policy addressed requirements of the Judgement Support Framework, with the exception of the following:

- The process used to risk-assess residents for recreational activities, including outdoor activities.
- The facilities available for recreational activities, including the identification of suitable locations for the provision of recreational activities.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a record of resident attendance. Activation Record forms were maintained by Community Employment (CE) employees and retained in residents’ clinical files. Analysis had been completed to identify opportunities to improve the processes for recreational activities. A meeting between management and the CE manager was held in relation to securing a third CE post.

Evidence of Implementation: Residents had access to appropriate recreational activities. Two individuals on a CE scheme facilitated recreational activities in the approved centre, including movies, TV, painting, bingo, jigsaws, puzzles, music, and hand massage. Nursing staff delivered recreational activities at the weekends. The approved centre also had access to a bus at weekends, but it was infrequently used.

Information was provided to residents in an accessible format, using a whiteboard. Recreational activities were developed, implemented, and maintained for residents, and an assessment chart was used to indicate the activities that residents might like to take part in. Where appropriate, individual risk assessments were completed for residents in relation to the selection of appropriate activities. Residents’ decisions on whether or not to participate in activities were respected and recorded in the Activation Record forms. Records of resident attendance at events were maintained in their clinical files.

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise. Residents were facilitated to walk in the internal courtyard garden. There were suitable indoor areas for recreation, including a designated activity corner and the sitting room.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 10: Religion

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in May 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy on religion had not been reviewed to ensure that residents’ identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. There was a multi-faith church in the approved centre, and residents had access to multi-faith chaplains. Following a risk assessment, residents could attend religious services outside of the approved centre, if deemed appropriate. The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in September 2016. It included requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to visits, as set out in the policy.

Monitoring: At the time of the inspection, there were no restrictions on residents’ rights to receive visitors. Analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. Residents could meet visitors in the sunroom in Selskar House or in a designated visiting room upstairs. Visits took place in private, unless there was an identified risk to the resident or others or a health and safety risk. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits.

Children were welcome when accompanied at all times to ensure their safety, and the visiting areas were suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 12: Communication

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in February 2015. It addressed requirements of the Judgement Support Framework, with the exception of the following:

- The circumstances in which resident communications may be examined by a senior member of staff.
- The individual risk assessment requirements in relation to limiting resident communication activities.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating residents’ communication needs, as set out in the policy.

Monitoring: At the time of inspection, there were no restrictions on resident communication. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to telephone, mail, and e-mail, and some residents had mobile phones. Staff supported residents who wanted to use the Internet. Individual risk assessments were completed for residents in relation to their external communication and documented in their individual care plans.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident’s dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in February 2015. It addressed all of the requirements of the Judgement Support Framework, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she was accommodated.
- The consent requirements of a resident regarding searches and the process for conducting searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

Training and Education: Relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for undertaking a search, as set out in the policy.

As no searches had been undertaken in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
Regulation 14: Care of the Dying

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to care of the dying, which was last reviewed in July 2015. It included requirements of the Judgement Support Framework, with the exception of a process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred to another facility.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policy.

Monitoring: End of life care had not been systematically reviewed to ensure section 2 of the regulation was complied with. There had been four deaths in the approved centre since the last inspection, none of which had been sudden. Analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: A review of clinical files indicated that end of life care plans were in place for residents who were dying. End of life care was appropriate to the residents’ physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, insofar as was practicable.

A single room was provided to residents at end of life to assure their privacy and dignity. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care, and pain management was prioritised and managed. Support was given to other residents and to staff following the deaths of residents.

There were Do No Attempt Resuscitation orders in the clinical files of five residents.
There had been four deaths of residents of the approved centre since the last inspection, and each had been notified to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan: “... a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation.”]

INSPECTION FINDINGS

Processes: The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in July 2015. It included requirements of the Judgement Support Framework, with the following exceptions:

- The required content in the set of documentation comprising the ICP.
- The time frames for assessment planning, implementation, and evaluation of the ICP.
- The provision of residents with access to their ICPs.

Training and Education: Not all clinical staff had signed the signature log, indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes relating to individual care planning. All multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: ICPs were audited on a quarterly basis to assess compliance with the regulation. Analysis had been completed to identify opportunities for improving the individual care planning process, and an action plan was put in place.

Evidence of Implementation: All of the residents had an ICP, and 20 of these were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. Residents received a comprehensive assessment at admission, and an initial care plan was put in place. Evidence-based assessments were used where possible.

The ICPs specified residents’ assessed needs and identified appropriate goals. They also identified the care and treatment required to meet those goals and the necessary resources to provide the care and treatment identified. The ICP was developed by the MDT within seven days of admission. In all of the ICPs inspected, a key worker was identified to ensure continuity in the implementation of an ICP. Each ICP included an individual risk management plan. The ICPs were reviewed by the MDT every six months. Following the review, a separate review form was populated and inserted in front of the ICP, effectively becoming the current ICP.

Not all residents had the ability to be involved in the development of their ICPs and there was no evidence of family involvement.

None of the ICPs examined contained preliminary discharge plans. In four of the ICPs examined, there was no evidence that the residents had been offered a copy of their ICPs and no explanation for this was
recorded. Similarly, in 18 ICPs, it was not recorded whether residents had declined or refused copies of their ICPs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and evidence of implementation pillars.
Regulation 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in August 2015. It addressed requirements of the Judgement Support Framework, with the exception of the facilities for the provision of therapeutic services and programmes.

Training and Education: Not all clinical staff had signed the signature log, indicating that they had read and understood the policy. All clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was not monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had not been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided were appropriate and met the assessed needs of residents, as documented in their individual care plans (ICPs). The specification of therapeutic services and programmes in residents’ ICPs was broad and did not detail any resident involvement. Two Community Employment workers ran a Sonas programme, a therapeutic activity for people with dementia, but they were not supervised. All other activities provided by the approved centre were recreational.

The psychologist visited the approved centre to assess residents and the social worker visited where necessary. At the time of the inspection, no occupational therapist was attached to the approved centre. There was no list of therapeutic services and programmes available to the residents at the time of inspection.

There was a generic recreation/activation plan, which did not include details of activities provided on a daily basis. There was no dedicated staff member available to deliver therapeutic activities and programmes. Records of residents’ participation and engagement in and the outcomes achieved in therapeutic services and programmes were not appropriately recorded or up to date.

Facilities were available that were suitable for group and one-to-one activities and programmes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 17: Children’s Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

INSPECTION FINDINGS

As the approved centre did not admit children, this regulation was not applicable.
Regulation 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in June 2015. It included requirements of the Judgement Support Framework, with the exception of processes for the following:

- Managing resident medications during transfer from the approved centre.
- Ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- Managing resident property during a transfer.
- Ensuring the safety of the resident and staff during the resident transfer process.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

Monitoring: The approved centre did not maintain a transfer log, and transfers were not systematically reviewed to ensure that all relevant information was provided to the receiving facility. Analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who was transferred to another health care facility in an emergency was inspected. This indicated that records of communication with the receiving facility were documented and that the resident had consented to the transfer. A pre-transfer assessment, including a risk assessment, was undertaken. Information regarding the resident was transferred to the receiving facility, including a letter of referral with a list of current medications and information on required medication for the resident during the transfer. The approved centre completed a checklist to ensure resident records were transferred to the receiving facility.

Although the clinical file indicated that a referral letter was sent to the receiving facility, a copy was not retained in the clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 19: General Health

(1) The registered proprietor shall ensure that:
   (a) adequate arrangements are in place for access by residents to general health services and for their referral to other
       health services as required;
   (b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any
       event not less than every six months, and;
   (c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for
    responding to medical emergencies.

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to the provision of general health care
    to residents: a general health policy dated December 2015 and a medical emergencies policy dated
    January 2016. The policies did not address the following requirements of the Judgement Support
    Framework:

    • The documentation of a medical emergency.
    • The management of the resuscitation trolley and Automated External Defibrillator (AED).
    • The process for providing residents with access to a registered medical practitioner.
    • The resource requirements for general health services, including equipment needs.
    • The protection of resident privacy and dignity during general health assessments.
    • The incorporation of general health needs into residents’ individual care plans.
    • The referral process for residents’ general health needs.
    • The documentation requirements in relation to general health assessments.

Training and Education: Not all clinical staff had signed the signature log, indicating that they had read
    and understood the policies. Clinical staff interviewed could articulate the processes for providing general
    health services and responding to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes was not recorded or monitored. A
    systematic review had been undertaken to ensure that six-monthly general health assessments of
    residents occurred, and a whiteboard contained details of the due dates for resident check-ups. Analysis
    was completed to identify opportunities to improve general health processes, leading to the introduction
    of an updated vital signs checklist.

Evidence of Implementation: The approved centre had an emergency trolley, and staff had access at all
    times to an AED. These were checked weekly. There had been no medical emergency in the approved
    centre since the last inspection.

A GP attended the approved centre every day, and all residents had medical cards. Residents received
    general health care interventions appropriate to their needs and in line with their individual care plans.
    Residents’ general health needs were monitored and assessed at least every six months, and the clinical
    files inspected indicated that all residents had completed six-monthly physical examinations. Adequate
    arrangements were in place for residents to access general health services and for their referral to other
health services, including a chiropodist, speech and language therapist, and dietitian. The completed general health checks were documented, and the associated results were recorded.

Residents had access to age- and gender-appropriate national screening programmes. No information was available regarding the national screening programmes available through the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

Processes: The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to the provision of information to residents, which was last reviewed in August 2015. It included requirements of the Judgement Support Framework, with the exception of the following:

- The process for identifying residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.
- The process for managing the provision of information to resident representatives, family, and next of kin.

Training and Education: Not all staff had signed the signature log, indicating that they had read and understood the policy. Staff interviewed could articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information was not monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Analysis had not been completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was given to residents and/or their representatives at admission in the form of a resident information booklet. Details were provided of the available care and services as well as of housekeeping arrangements, complaints procedures, and visiting times and arrangements. Details of relevant advocacy and voluntary agencies were displayed on a poster on the noticeboard. No information was provided in relation to residents’ rights.

Residents were provided with information on their multi-disciplinary team during their initial individual care plan meeting. They received mainly verbal information regarding their diagnosis, unless, in the view of the treating psychiatrist, this might be prejudicial to their physical or mental health, well-being, or emotional condition.
Information relating to diagnosis and medication information was available in the form of a booklet, which included information on indications for the use of all medications administered to residents such as risks and side effects. The medication information booklet was in need of review. Medication leaflets available in the approved centre were accessible and easy to read, and they contained evidence-based information.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 21: Privacy

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

**INSPECTION FINDINGS**

**Processes:** The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to resident privacy, which was last reviewed in July 2015. It included requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities for the provision of resident privacy and dignity.
- The identification of residents’ privacy and dignity expectations and preferences.
- The process applied when residents’ privacy and dignity were disrespected by staff.

**Training and Education:** Not all staff had signed the signature log, indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

**Monitoring:** An annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

**Evidence of Implementation:** Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful and friendly manner. Staff were appropriately attired, sought permission before entering residents’ rooms, and conducted all conversations relating to residents’ clinical and therapeutic needs in private. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and some single rooms had locks on the inside of the doors, and these had an override facility. Not all single rooms could be locked.

All observation panels on doors of treatment rooms and bedrooms were appropriately screened, and bedrooms on exterior walls had window blinds for privacy. Residents were facilitated in making and taking private phone calls. The noticeboard in the nurses’ station displayed the list of residents in the approved centre but was not visible to members of the public.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and
       implemented and records of such programme are maintained.
(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the
    number and mix of residents in the approved centre.
(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre
    environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and
    well-being of residents, staff and visitors.
(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the
    commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose
    in so far as it practicable and in accordance with best contemporary practice.
(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the
    commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with
    disabilities.
(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and

INSPECTION FINDINGS

Processes: The approved centre used the generic Waterford/Wexford Mental Health Services policy in relation to its premises, which was last reviewed in August 2015. The policy addressed the roles and responsibilities for the maintenance of the approved centre’s premises and related processes. It did not address any of the other requirements of the Judgement Support Framework:

- The legislative requirements to which the premises must conform.
- The approved centre’s maintenance programme.
- The approved centre’s cleaning programme.
- The approved centre’s utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The process for identifying hazards and ligature points.

Training and Education: Relevant staff had signed the signature log, indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed hygiene and ligature audits. Analysis had been completed to identify opportunities for improving the premises. The approved centre was awaiting approval for a garden-enhancement plan.

Evidence of Implementation: Residents had access to personal space, in the form of single rooms with en suite facilities that were furnished to ensure comfort and privacy and to meet the assessed needs of residents. Appropriately sized communal rooms were available, including two television rooms and a dining area where residents could sit during the day.
The approved centre was comfortably heated and ventilated, and communal areas were adequately lit to facilitate reading and other activities. Sufficient spaces were provided for residents to move about, including three outdoor areas.

Signage was in place on bedrooms and toilets, but it did not always support resident orientation needs. A toilet sign that projected out from the wall was required but had not been sourced at the time of inspection. Not all ligature points had not been mitigated. A ligature audit had highlighted a number of points assessed as moderate risk and one high-risk point. Some of these had been removed, others were managed through risk assessments.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised.

The approved centre was in a good state of repair. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Maintenance was reactive, with problems reported to the technical services department as they arose. A cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours. National infection control guidelines were followed.

There were adequate toilet and bathroom facilities, including assisted needs facilities. There were designated sluice, cleaning, and laundry rooms. There were no dedicated examination rooms, and all examinations were undertaken in residents’ bedrooms or the clinical room. Bedrooms were appropriately sized to address residents’ needs, and furnishings throughout the approved centre supported residents’ independence and comfort. Assisted devices and/or equipment were available, where required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in July 2015. It addressed requirements of the Judgement Support Framework, with the exception of the following:

- The legislative requirements and professional codes of practice to be complied with during the ordering, prescribing, storing, and administration of medication.
- The process for crushing medications.
- The processes for managing medication at admission, transfer, and discharge.
- The process for reconciling medication.
- The process for reviewing resident medication.

Training and Education: Not all nursing, medical staff, and pharmacy staff had signed the signature log, indicating that they had read and understood the policy. Nursing and medical staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to up-to-date information on all aspects of medication management. There was documentary evidence that all nursing, medical, and pharmacy staff had received training on medication errors.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication issues. Analysis had been completed in relation to identifying opportunities to improve the process relating to the crushing of medication.

Evidence of Implementation: An MPAR was maintained for each resident, and 14 of these were inspected. Two appropriate resident identifiers were used when medication was being administered, including name, date of birth, and photographic ID.

Names of medications were written in full, and generic names were recorded where applicable. The frequency of administration, the dosage, and the administration route for medications were documented. The initiation and discontinuation dates for medications were recorded. Each MPAR entry was accompanied by the signature of the medical practitioner.

The allergy section was not completed in nine of the MPARs inspected.

Residents’ medication was reviewed on a six-monthly basis by the GP and at the individual care plan review. Where there was an alteration in the medication order, the medical practitioner rewrote the
Medication was appropriately administered by a registered nurse or registered medical practitioner, and pharmacy input came from the pharmacist from Wexford General Hospital.

The expiration date of medication was checked prior to administration, and good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. Where a resident’s medication was withheld or refused, the justification was noted in the MPAR and documented in the respective clinical file.

At the time of the inspection, no controlled drugs were being prescribed to residents. Twelve residents were receiving crushed medication, and directions to crush the medication were only accepted from their medical practitioner. Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. A daily log of medication fridge temperatures was maintained.

The medication trolley was locked and secured, and scheduled controlled drugs were secured in a separate cupboard. Medication storage areas were free from damp and mould and were clean and well maintained. No food or drinks were stored in areas used for storing medication. A system of stock rotation was in place, and an inventory of medications was completed monthly. Expiry dates were checked on all medications once a month, and medications that were no longer required were securely stored and returned to the pharmacy for disposal.

Medication storage areas were not incorporated into the cleaning and housekeeping schedules.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

**INSPECTION FINDINGS**

**Processes:** The approved centre had three written policies relating to health and safety: a health and safety policy dated March 2016, a Selskar House safety statement dated 2016, and the HSE’s corporate safety statement dated 2014. Together, the policy and safety statements addressed requirements of the Judgement Support Framework, with the exception of the following:

- The allocation of specific roles to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- The monitoring and continuous improvement requirements implemented for the health and safety processes.

**Training and Education:** Not all staff had signed the signature log, indicating that they had read and understood the policy and safety statements. Staff interviewed were able to articulate the processes relating to health and safety, as set out in these documents.

**Monitoring:** The health and safety policy was monitored pursuant to Regulation 29: Operational Policies and Procedures.

**Evidence of Implementation:** Regulation 24 was only assessed against the approved centre’s written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.
Regulation 25: Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
(b) it shall be clearly labelled and be evident;
(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff, which was last reviewed in April 2016. It also used a recruitment code of practice as well as relevant HSE human resources circulars. These documents included requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment of staff.
- The approved centre’s recruitment, selection, and appointment process, including Garda vetting requirements.

The policies did not address the following:

- The organisational structure of the approved centre, including lines of responsibility.
- The staff rota details and the methods used for their communication to staff.
- Staff performance and evaluation requirements.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The required qualifications of training personnel.
- The evaluation of training programmes.

Training and Education: All relevant staff had signed the signature log, indicating that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

Monitoring: The implementation and effectiveness of the staff training plan had not been reviewed annually. The numbers and skill mix of staff had been assessed against the levels recorded in the approved centre’s registration. Analysis had not been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place to identify the leadership and management structure and lines of authority and accountability in the approved centre. A planned and
actual staff rota was in place. Staff were recruited, selected, and vetted in line with the approved centre’s policies. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency. The approved centre had identified a need for an occupational therapist. This post had been filled, however the staff member was on extended leave at the time of inspection.

The approved centre provided a written staffing plan to the inspection team. Annual staff training plans had also been completed to identify required training and skills development in line with the assessed needs of the resident group profile.

Orientation and induction training had been completed by staff, but not all health care professional were up to date with their training in fire safety, Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act (MHA) 2001.

Two staff members were trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training provided in manual handling, infection control and prevention, risk management, incident reporting, and the protection of children and vulnerable adults.

Staff training was documented, and staff training logs were maintained. Resources were available to staff for further training and education, and in-house trainers were appropriately qualified. The MHA 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in the approved centre.

The following is a table of clinical staff assigned to the approved centre.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selskar House</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

The approved centre was non-compliant with this regulation for the following reasons:

a) Not all staff had up-to-date mandatory training in fire safety, BLS, the management of violence and aggression, and the MHA 2001, 26(4) and (5).

b) There was no occupational therapist in the approved centre at the time of inspection, meaning that the skill mix of staff was not appropriate to meet the assessed needs of the residents, 26(2).
Regulation 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.


Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation, which refers only to maintenance of records pertaining to these areas.

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to the maintenance of records: a maintenance of records policy, which was last reviewed in June 2017, and the HSE’s 2011 standards and recommended practices for healthcare record management. Together, the policies addressed all of the requirements of the Judgement Support Framework, including policies and procedures relating to the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.
- The destruction of records.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log, indicating that they had read and understood the policies. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records in the approved centre. All clinical staff had received training in best-practice record keeping at induction.

Monitoring: Resident records had not been audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: Records were secure, up to date, in good order, and constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and national guidelines and legislative requirements.

Resident records were physically stored together in the secure nurses’ office in a lockable trolley. All residents had a record that was reflective of their current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence, and entries were factual, consistent, and accurate.
Not all entries included the date and the time, using the 24-hour clock.

Residents’ records were accessible to authorised staff only, and only authorised staff made entries in them. Documentation relating to health and safety, food safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring, and evidence of implementation pillars.
## Regulation 28: Register of Residents

**COMPLIANT**

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

### INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date and contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.
Regulation 29: Operating Policies and Procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the development, management, and review of operating policies and procedures, which was last reviewed in June 2017. It addressed requirements of the Judgement Support Framework, with the exception of the process for making obsolete and retaining previous versions of operating policies and procedures and the standardised layout used for operating policies and procedures.

Training and Education: Not all relevant staff had signed the signature log, indicating that they had read and understood the policy. Not all relevant staff had received training on approved operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes relating to the development and review of policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. A policy group within the Community Healthcare Organisation met regularly to develop and review policies. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Operating policies and procedures were communicated to all relevant staff. All operating policies and procedures required by the regulations had been reviewed within three years. Where generic policies were used, the approved centre had a written statement to this effect, adopting the generic document.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 30: Mental Health Tribunals

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(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

**INSPECTION FINDINGS**

As the approved centre had not admitted an involuntary patient since the last inspection, this regulation was not applicable.
Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident’s individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in July 2015. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had received training on complaints management processes at induction. Not all staff had signed the signature log, acknowledging that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: At the time of the inspection, there were no complaints recorded in the complaints log.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner, using the HSE’s Your Service, Your Say process. The approved centre’s complaints management processes were well publicised and accessible to residents and their representatives. Information on complaints procedures was provided in the information booklet given to residents at admission and advertised on noticeboards in the approved centre.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged. Minor complaints were dealt with locally by the staff involved or the clinical nurse manager 2 and recorded in the complaints log.
All non-minor complaints were addressed by the complaints officer and recorded in the complaints log. Details of complaints, subsequent investigations, and outcomes were documented and kept distinct from the resident individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.
Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
   (i) resident absent without leave,
   (ii) suicide and self harm,
   (iii) assault,
   (iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management, which was last reviewed in June 2016. It also used the HSE’s generic risk management policy. Together, the policies addressed requirements of the Judgement Support Framework, including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring of health and safety risks to the residents, staff, and visitors.
- Rating identified risks.
- Controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents of the approved centre.
- Responding to emergencies.
- Protecting children and vulnerable adults in the care of the approved centre.

The policies did not address the following:

- The person with overall responsibility for risk management.
- The process for the identification, assessment, treatment, reporting, and monitoring of the following risks:
  - Organisational risks.
  - Structural risks such as ligature points.
  - Capacity risks relating to the number of residents in the approved centre.
  - Risks to the resident group during the provision of general care and services.
  - Risks to individual residents during the delivery of individualised care.
Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management, and managerial staff were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log, indicating that they had read and understood the policies. Staff interviewed were able to articulate the risk management processes, as set out in the policies. All training was documented.

Monitoring: The risk register was reviewed every three months to determine compliance with the approved centre’s risk management policy. All incidents were documented and risk-rated. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest practical level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored. A ligature audit had been completed, after which high-rated risks were mitigated.

The approved centre completed resident risk assessments at admission to identify individual risk factors. Assessments were also completed before and during the use of mechanical restraint, prior to resident transfer, and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of risk management processes, as did residents and/or their representatives. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using a standard format, and all clinical incidents were reviewed by the MDT and documented. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service. Six-monthly summary reports of all incidents were submitted to the Mental Health Commission in line with the Code of Practice on the Notification of Deaths and Incident Reporting. The approved centre had an emergency plan, which incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
## Regulation 33: Insurance

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

### Inspection Findings

The approved centre’s insurance certificate was provided to the inspection team. It confirmed that the approved centre was insured under the auspices of the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.
### Regulation 34: Certificate of Registration

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<th><strong>COMPLIANT</strong></th>
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The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed.

The approved centre was compliant with this regulation.
10.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
   (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
   (b) where the patient is unable to give such consent –
      (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist
          responsible for the care and treatment of the patient, and
      (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant
          psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-
convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this rule was not applicable.
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) “A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section “patient” includes –
   (a) a child in respect of whom an order under section 25 is in force, and
   (b) a voluntary patient.

INSPECTION FINDINGS

As the approved centre did not use seclusion, this rule was not applicable.
Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section “patient” includes –
   (a) a child in respect of whom an order under section 25 is in force, and
   (b) a voluntary patient.

INSPECTION FINDINGS

The clinical files of six residents who had been prescribed mechanical restraint were inspected.

In each case, mechanical restraint was used to address an identified clinical need. The restraint was ordered by a registered medical practitioner under the supervision of the treating consultant psychiatrist. The clinical files indicated the type of mechanical restraint used, the duration of the restraint and of the order, and the review date of the mechanical restraint.

None of the files inspected documented whether less restrictive alternatives had been implemented without success before the use of mechanical restraint, and five files did not reference the situation in which mechanical restraint was being applied.

The approved centre was non-compliant with this rule for the following reasons:

   a) There was no evidence that least restrictive alternatives had been implemented without success before the use of mechanical restraint, 21.5(b).
   b) Five of the clinical files inspected did not reference the situation in which mechanical restraint was being applied, 21.5(d).
11.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

56. In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where –
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either –
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent –
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61. Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent, or as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

INSPECTION FINDINGS

As no involuntary patients had been admitted to the approved centre since the last inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
12.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

The Mental Health Act, 2001 (“the Act”) does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Use of Physical Restraint

Please refer to the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint, which was dated June 2017. The policy, which had been reviewed annually, included details of the following:

- The provision of information to residents regarding the use of physical restraint.
- The individuals authorised to initiate and implement physical restraint.
- The training requirements relating to physical restraint.

Training and Education: Staff involved in the use of physical restraint had signed the signature log, indicating that they had read and understood the policy. Staff interviewed were able to articulate the process relating to physical restraint, as outlined in the policy. A staff training plan was in place, which specified who should receive training, areas to be addressed during training, frequency of training, the identification of appropriately qualified individuals to deliver training, and the mandatory nature of training in the use of physical restraint. A record of attendance at training was maintained.

As no episode of physical restraint had been recorded in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this code of practice were not inspected against.

The approved centre was compliant with this code of practice.
### Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

### INSPECTION FINDINGS

As children were not admitted to the approved centre, this code of practice was not applicable.
Notification of Deaths and Incident Reporting

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre’s risk management policy, care of the dying policy, and notification of death policy addressed the reporting of deaths and incidents to the Mental Health Commission (MHC). The policies specified the risk manager and outlined the roles and responsibilities of staff in relation to the reporting of deaths and incidents and the completion of death notification forms.

The policies did not address the roles and responsibilities in relation to the submission of forms to the MHC or the completion of six-monthly incident summary reports.

Monitoring: Deaths and incidents were reviewed to identify and correct any problems as they arose and to improve quality processes.

Evidence of Implementation: The approved centre was compliant with Regulation 32: Risk Management Procedures. It used the National Incident Management System to report incidents, and the incident report forms were available to the inspector. A six-monthly summary of all incidents was sent to the MHC.

There had been four deaths of residents of the approved centre since the last inspection, and these had been notified to the MHC within the required 48-hour time frame.

The approved centre was non-compliant with this code of practice because its policies did not address the roles and responsibilities for the submission of forms to the MHC and the completion of six-monthly incident summary reports, 4.3.
**Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities**

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

**INSPECTION FINDINGS**

As there were no residents in the approved centre who had been diagnosed with an intellectual disability, this code of practice was not applicable.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

<table>
<thead>
<tr>
<th>NOT APPLICABLE</th>
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</thead>
</table>

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

**INSPECTION FINDINGS**

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.
# Admission, Transfer and Discharge

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

## INSPECTION FINDINGS

### Processes: The approved centre had separate policies in relation to admission, transfer, and discharge.

**Admission:** The admission policy addressed all of the criteria of this code of practice, including a protocol for planned admission with reference to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. It contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams. There was also a policy on confidentiality, privacy, and consent.

**Transfer:** The transfer policy detailed how a transfer was arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary transfer and emergency transfer. It did not reference transfer abroad or the safety of the resident and staff during a resident transfer.

**Discharge:** The discharge policy referenced prescriptions and supply of medication on discharge, and it included protocols for discharging homeless people and older people. It contained a process for managing discharge against medical advice, and it detailed follow-up procedures. The policy did not reference the discharge of people with an intellectual disability or include a procedure for the discharge of involuntary patients.

**Training and Education:** There was no documented evidence that all staff had read and understood the policies on admission, transfer, and discharge.

**Monitoring:** There was no documented evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.

### Evidence of Implementation:

The approved centre was compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

**Admission:** One clinical file was inspected in relation to admission. The approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). An admission assessment was completed and documented in the clinical file. It included a history of the presenting problem, previous psychiatric history, family history, medical history, current and historical medication, social history, mental state examination, and full physical examination. Family members/carers were involved in the admission process. Residents were admitted to a unit most appropriate to their needs.
The approved centre’s admissions process was compliant under the following regulations associated with this code of practice: Regulation 8: Residents’ Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records. It was not compliant with Regulation 7: Clothing.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The file of one resident who had been transferred to another health care facility in an emergency was examined. The decision to transfer was made by the RMP and a pre-transfer assessment was undertaken. An effort was made to respect the resident’s wishes and obtain consent. Family members/carers/advocates were involved in the transfer process, as were members of the MDT. A copy of the referral letter was not retained in the resident’s clinical file.

Discharge: The clinical file of one resident was examined in relation to discharge. The decision to discharge was made by the RMP, and a discharge meeting took place, which was attended by the resident, key workers, members of the MDT, and a family member. The resident had a comprehensive assessment prior to the discharge, which was coordinated by the key worker. A preliminary discharge summary was issued to the primary care/community mental health team within three days, followed by a comprehensive discharge summary within 14 days. A family member was involved in the discharge process.

The resident’s individual care plan did not include a discharge plan. There was no evidence that the approved centre reviewed inspection reports for the nursing home to which the resident was transferred to facilitate selection of the most appropriate facility.

The approved centre was non-compliant with this code of practice for the following reasons:

a) The transfer policy did not include provisions for a transfer abroad or for ensuring the safety of the resident and staff during a transfer, 4.13.

b) The discharge policy did not include a protocol for discharging involuntary patients, 4.2.

c) The discharge policy did not include a protocol for the discharge of people with an intellectual disability, 4.16.

d) There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge, 9.1.

e) There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.

f) The approved centre did not comply with Regulation 7: Clothing, which is associated with this code of practice, 23.1.

g) The clinical file inspected in relation to transfers did not contain a copy of the referral letter, 31.2.

h) There was no discharge plan in place as part of the discharged resident’s individual care plan, 34.1 and 34.2.

i) There was no evidence that the approved centre reviewed inspection reports for the nursing home to which the resident was discharged, 44.2.
# Appendix 1: Corrective and Preventative Action Plans

## Regulation 7: Clothing

*Report reference: Page 19*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tbody>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>1. No emergency supply of underwear was available.</td>
<td>New</td>
<td>Corrective Action(s): Reserve levels (10) of both gender’s underwear have been sourced. The minimum reserve level has been set at (5) which will trigger the ordering process to restore the deficit to the minimum level. Post-Holder(s) responsible: CNMII</td>
<td>Reserve levels will be routinely monitored on a six monthly basis. A recording sheet will be utilised to record routine six monthly reserve checks. Any removal of underwear stocks during admissions will also be recorded on reserve sheets.</td>
<td>None</td>
</tr>
</tbody>
</table>

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\(^1\) Area of non-compliance reoccurring from 2016  
\(^2\) Area of non-compliance new in 2017
## Regulation 26: Staffing

**Report reference: Page 45-46**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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| 2. Not all staff had up-to-date mandatory training in fire safety, BLS, the management of violence and aggression, and the MHA 2001. | Reoccurring | **Corrective Action(s):** A schedule of training has been co-ordinated through each Head of Discipline in order to ensure compliance with mandatory training requirements.  
- Fire safety training – a further 12 staff have received training in March 2017.  
- BLS: A further 11 staff have received training since June 2017.  
- TMVA further 4 staff have undertaken training in the third quarter of 2017  
- MHA 2001 – A further 6 staff have completed training on line through e-learning. | Each Head of Discipline will conduct an annual audit to review training uptake and establish action plans to ensure staff have up to date mandatory training.  
All attendance at training will be recorded and updated on training database  
Heads of Disciplines will monitor compliance on an ongoing basis. | While 100% compliance will be sought, maintenance of safe staffing levels, the use of agency and lack of staff continuity may hinder the achievement of 100% compliance. | March 2018  
Ongoing (A further 3 Fire Safety Training Modules scheduled for 06/12/2017)  
BLS training is facilitated on an ongoing basis.  
The next training schedule for TMVA will commence in January 2018Staff have been reminded of the importance of undertaking this training on HSEland |
| 3. There was no occupational therapist in the approved centre at the time of inspection, meaning that the skill mix of staff was not appropriate to meet the assessed needs of the residents. | New | **Corrective Action(s):** An Occupational Therapist has been appointed to the Selskar House MDT since Sept 2017 thereby ensuring the skill mix is appropriate to the assessed needs of the residents. | Completed | None | Immediate |

Post-Holder(s) responsible: HOD’s

Post-Holder(s) responsible: Service Manager
## Section 69: The Use of Mechanical Restraint

Report reference: Page 61

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>4. There was no evidence that least restrictive alternatives had been implemented without success before the use of mechanical restraint.</td>
<td>New</td>
<td>Corrective Action(s): The Consultant Psychiatrist will ensure that there is documentary evidence within each relevant healthcare record, that least restrictive alternatives had been implemented without success before the use of mechanical restraint. The form authorising the use of mechanical restraint for enduring risk of harm has been updated to prompt locum medical practitioners to document that least restrictive alternatives have been implemented without success. Post-Holder(s) responsible: Consultant Psychiatrist</td>
<td>Completed</td>
<td>Achievable</td>
</tr>
<tr>
<td>5. Five of the clinical files inspected did not reference the situation in which mechanical restraint was being applied.</td>
<td>New</td>
<td>Corrective Action(s): In line with MHC rules 2009, the Consultant Psychiatrist will ensure that the situation in which mechanical restraint is being applied is documented within the relevant healthcare records. The form for authorising mechanical restraint will be reviewed to include prompts to ensure locum practitioners are aware of this requirement. Post-Holder(s) responsible: Consultant Psychiatrist</td>
<td>Completed</td>
<td>None</td>
</tr>
</tbody>
</table>
## Code of Practice: Notification of Deaths and Incident Reporting

**Report reference:** Page 67

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</tr>
<tr>
<td>6. Policies did not address the roles and responsibilities for the submission of forms to the MHC and the completion of six-monthly incident summary reports.</td>
<td>New</td>
<td><strong>Corrective Action(s):</strong> The Notification of Deaths and Incident Reporting Policy will be reviewed to clearly articulate the roles and responsibilities for the submission of forms to the MHC and the completion of six monthly summary reports. Post-Holder(s) responsible: CHO Policy Group</td>
<td>An annual audit of required policy formulation and review is conducted by the chair of the CHO 5 Policy Group.</td>
<td>None</td>
</tr>
</tbody>
</table>
## Code of Practice: Admission, Transfer and Discharge

### Report reference: Page 70-71

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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</tr>
<tr>
<td>7. The transfer policy did not include provisions for a transfer abroad or for ensuring the safety of the resident and staff during a transfer.</td>
<td>Reoccurring</td>
<td><strong>Corrective Action(s):</strong> The transfer policy will be amended to include provisions for transfer abroad and safety of the resident and staff during transfer. The discharge policy will be reviewed to include a protocol for discharging involuntary patients and a protocol for the discharge of people with an intellectual disability.</td>
<td>An annual audit of required policy formulation and review is conducted by the chair of the CHO 5 Policy Group. An annual audit of required policy formulation and review is conducted by the chair of the CHO 5 Policy Group.</td>
<td>None</td>
</tr>
<tr>
<td>8. The discharge policy did not include a protocol for discharging involuntary patients.</td>
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<tr>
<td>9. The discharge policy did not include a protocol for the discharge of people with an intellectual disability.</td>
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<td></td>
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<tr>
<td>10. There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge.</td>
<td>New</td>
<td><strong>Corrective Action(s):</strong> A focused effort has been made to ensure all relevant staff have read and signed the admission, transfer and discharge policies. The CNM 2 reiterates the requirement for policy sign off as part of routine handover. Signage has been put up in the team meeting room to remind off of the requirement to sign policies as evidence they have been read and understood.</td>
<td></td>
<td>None</td>
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</tbody>
</table>

Post-Holder(s) responsible: CNM2s and Heads of Disciplines and CNM2 and Heads of Discipline will monitor policy sign off on an ongoing basis and as new policies are disseminated.
### 11. There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies.

**New**

**Corrective Action(s):**
- An annual audit will be carried out by the CNM 2 to ascertain if admission and discharge policies have been adhered to. This may incorporate the use of self assessment tools within the Best Practice Guidelines for Mental Health 2017.
- Training on self assessment using Best Practice Guidelines for Mental Health 2017 will be sought for the CNM 2 and A/ADON for Selskar House.
- Post-Holder(s) responsible: CNM II and A/DON

**The relevant audit reports will be available on site once completed.**

### 12. The clinical file inspected in relation to transfers did not contain a copy of the referral letter.

**New**

**Corrective Action(s):**
- All clinical staff have been made aware of the requirement for ensuring a copy of transfer letter is kept within the relevant healthcare record, including all night staff.
- All future transfer letters will be photocopied and a copy filed in the relevant healthcare record.
- Post-Holder(s) responsible: CNMII

**Immediate**

**The CNM 2 will audit adherence to this requirement following each transfer from the unit.**

### 13. There was no discharge plan in place as part of the discharged resident’s individual care plan.

**New**

**Corrective Action(s):**
- The existing discharge plan documentation, within the ICP booklet will be completed for all residents where deemed appropriate, in line with JSF, 2017. This discharge plan will be monitored and updated prior to discharge.
- Post-Holder(s) responsible: MDT/ Keyworker

**On going**

**The CNM2 will ensure discharge plans are updated by the MDT prior to residents’ discharge.**
14. There was no evidence that the approved centre reviewed inspection reports for the nursing home to which the resident was discharged.

| New | Corrective Action(s): An additional facility will be added to the existing discharge plan to facilitate the recording that the inspection reports for the nursing home to which the resident is to be discharged, have been reviewed. Post-Holder(s) responsible: CNM 2 | Completed | None | Completed |