Grangemore Ward & St. Aidan's Ward, St. Otteran's Hospital

ID Number: AC0033

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Grangemore Ward & St Aidan's Ward, St Otteran's Hospital
John's Hill
Waterford

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, General Manager, CHO5 Mental Health Services

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Inspection Date:
20 – 23 August 2018

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
17 – 20 October 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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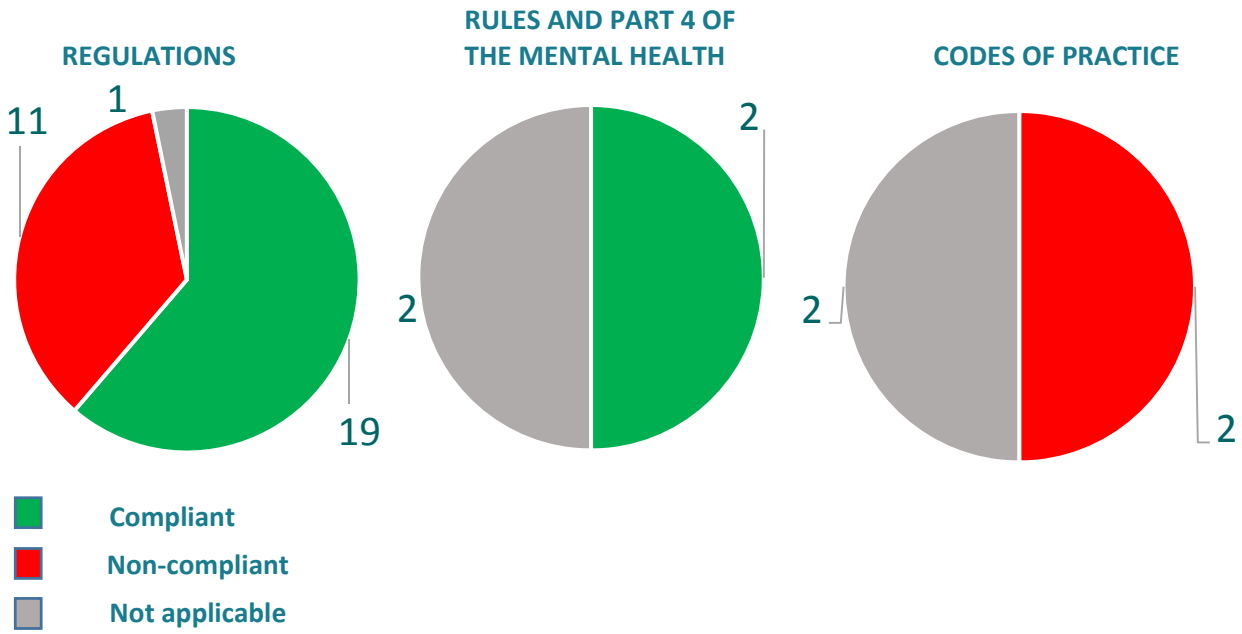
14 February 2019

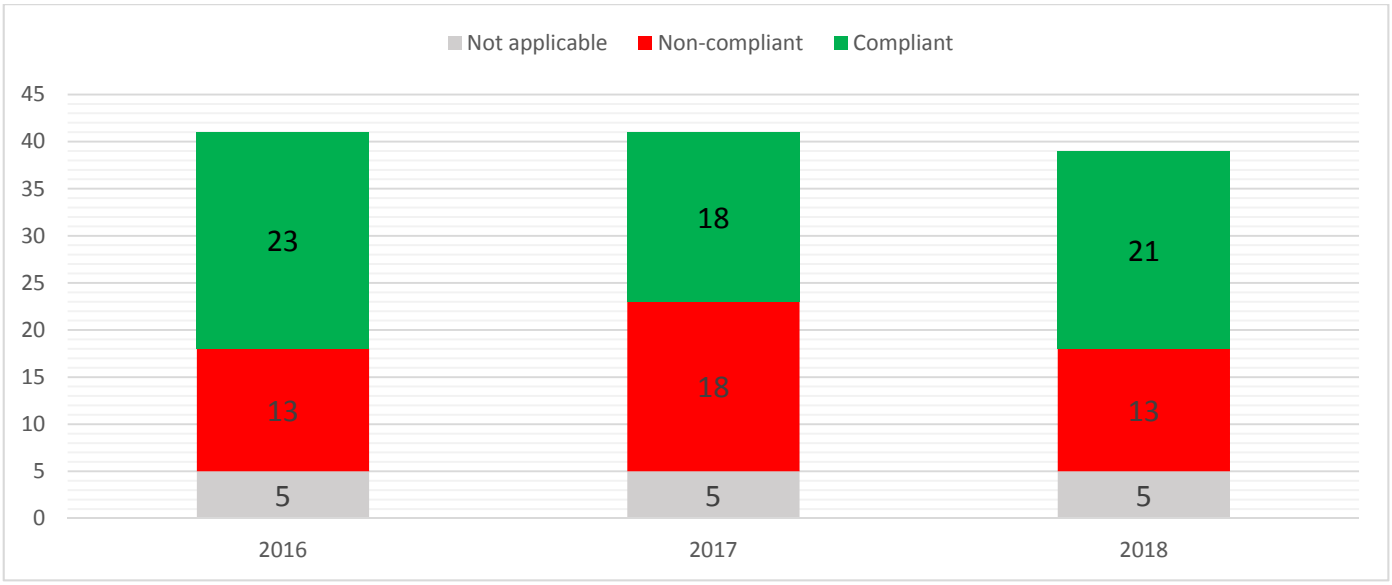
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

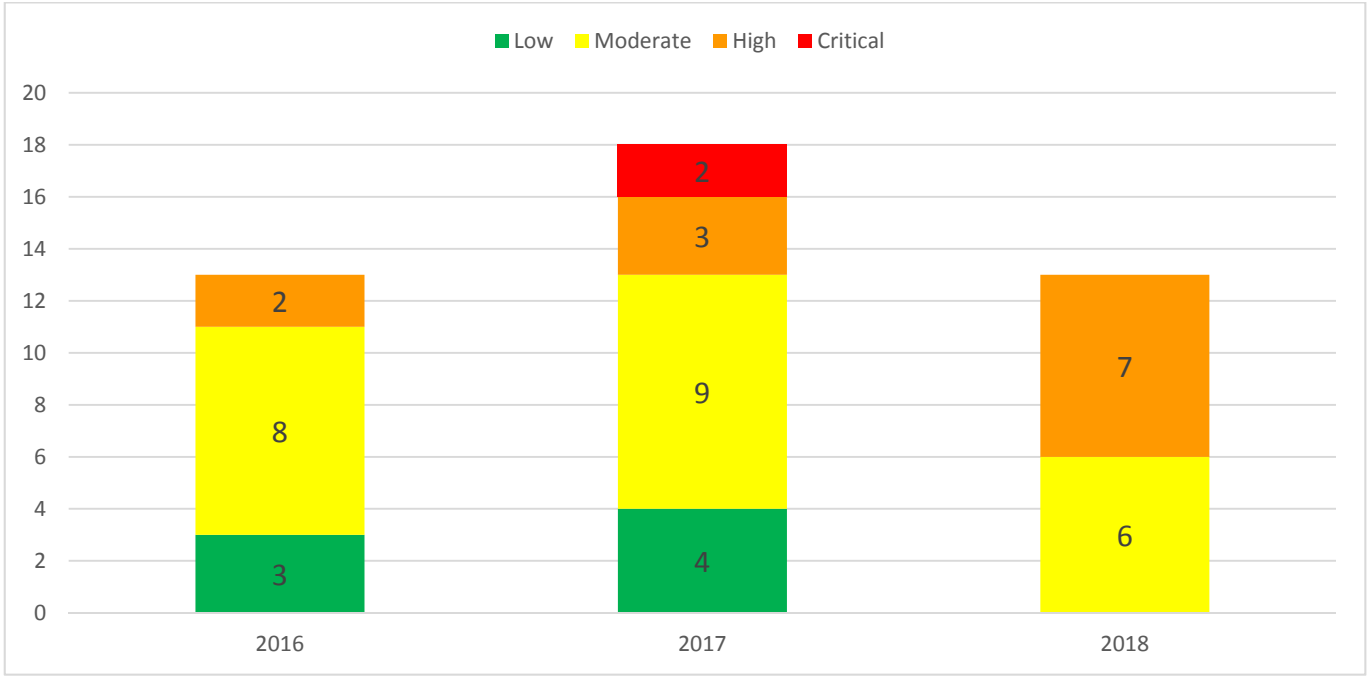
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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 2016 – 2018



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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.

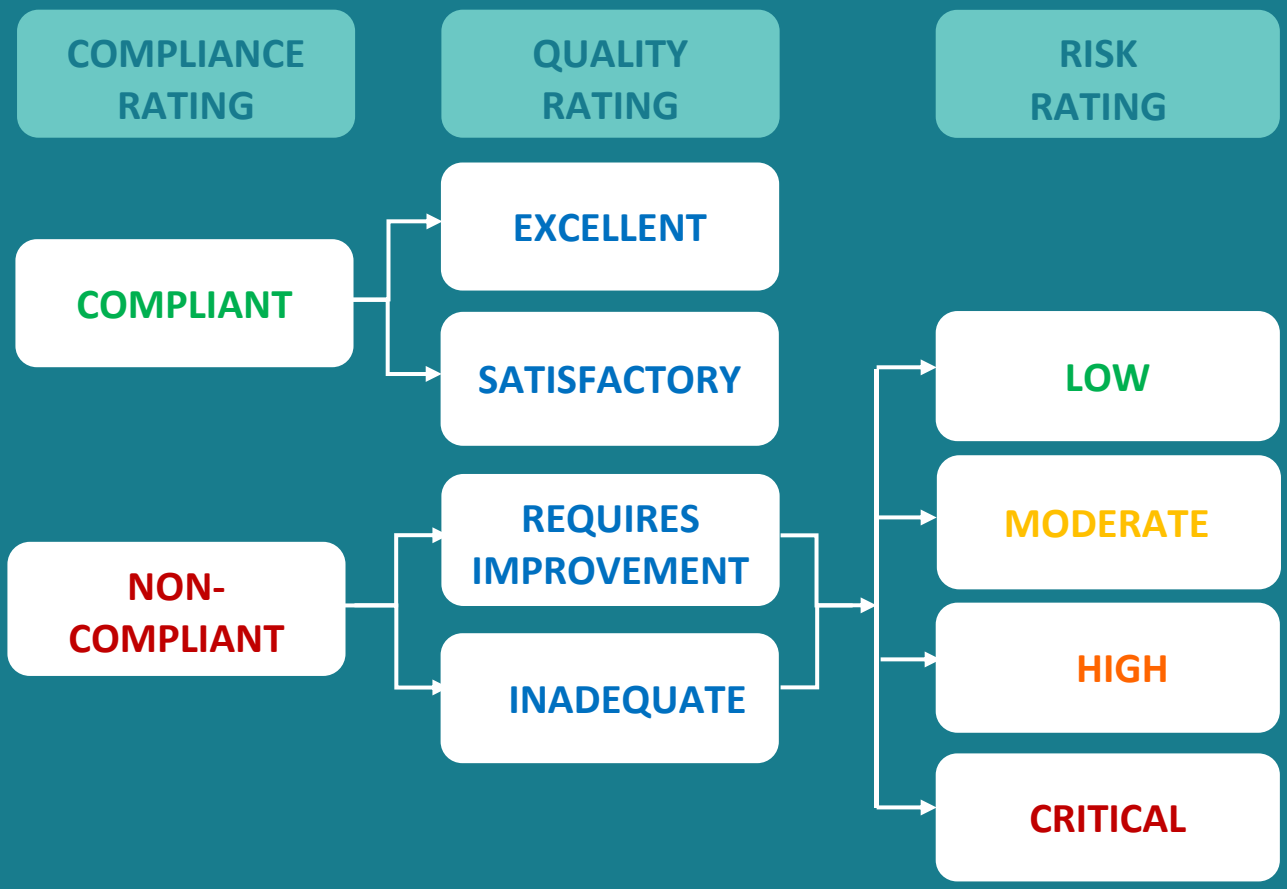
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, 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.

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
QUALITY RATINGS are generally given for all regulations, except for 28, 33 and 34.
RISK RATINGS are given for any area that is deemed non-compliant.



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, achievable, realistic, 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 — Dr Susan Finnerty

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.

In Brief

Grangemore ward and St. Aidan's ward were on the campus of St. Otteran's Hospital, Waterford. Grangemore ward was under the care of the rehabilitation and recovery team, and St. Aidan's ward was under the care of the psychiatry of old age team and the rehabilitation and recovery team. Grangemore ward had 16 beds with an occupancy of 15 and St. Aidan's ward had 24 beds with an occupancy of 14 at the time of inspection. Both wards were in need of refurbishment and there was no programme of planned general maintenance in the approved centre.

Residents who spoke with the inspectors or filled out questionnaires raised the lack of knowledge or involvement in individual care plans, lack of access to adequate activities during the day, lack of clarity regarding the identity of keyworkers, and uncertainty regarding the procedure to raise complaints. A number of concerns were raised regarding lack of adequate space for privacy.

There were no conditions attached to registration of the approved centre. The approved centre has had difficulty in improving compliance with regulations, rules and codes of practice over the past three years: 64% compliance in 2016; 50% compliance in 2017 and 62% compliance in 2018. There were no compliances rated as excellent on this inspection.

Safety in the approved centre

Each resident had at least two personal identifiers. Medication was stored appropriately and safely. There were errors in the recording of the administration of medication and in the written prescriptions.

There was a sufficient number of toilets and showers for residents in Grangemore ward but not in St. Aidan's ward. Nine male residents in St. Aidan's had the use of a single toilet. For clinical reasons, one resident required dedicated use of one out of a total of two toilets on the ward.
The numbers and skill mix of staffing was inadequate to meet residents' needs, and the size and layout of the approved centre. There were attempts to mitigate staff shortages by using agency staff, staff overtime, and by moving staff from services within the Waterford and Wexford Mental Health Services. Despite this,

rosters evidenced that the approved centre did not always have the registered numbers of staff required on duty each day.

Training of staff was inadequate to meet the needs of the residents. Not all staff were trained in wound care, dementia care, risk management and treatment, and incident reporting. Staff were not trained in manual handling, infection control and prevention, end of life care, recovery-centred approaches to mental health care and treatment, resident rights, caring for residents with an intellectual disability, and the protection of children and vulnerable adults.

Not all health care staff were trained in the following: fire safety, Basic Life Support, management of violence and aggression and The Mental Health Act 2001.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary care plan which was satisfactory. Therapeutic programmes and services were insufficient, were not varied, and were narrow in scope for residents living at St Aidan's ward. All residents in St. Aidan's ward were offered dog therapy and garden therapy only, and they had access to 0.4 (whole time equivalent) of an occupational therapist. There were no one-to-one occupational therapy sessions.

While residents in Grangemore ward could access a dietitian on a referral basis from their own GP to have their special dietary needs assessed, residents in St. Aidan's ward could not. Specifically, in St. Aidan's ward, there was no access to a dietitian for residents with special dietary requirements who were unable to access dietetic services externally.

Adequate arrangements were not in place for residents to access general health services and be referred to other health services, as required. Six clinical files inspected showed that not all residents received appropriate general health care interventions in line with their individual care plans. Residents in Grangemore ward had access to a community GP when required, but residents in St. Aidan's ward did not have access to a GP. Instead, the non-consultant hospital doctor assessed the residents in St. Aidan's on admission, and when issues arose. There was no on-going medical monitoring of residents' general health needs. Residents in St. Aidan's did not have access to a dentist for regular dental health checks.

Residents had inadequate access to the tissue viability nurse in St. Aidan's ward. There was evidence that residents were getting grade two pressure ulcers which were being referred to the tissue viability nurse. While nursing advice in relation to pressure ulcers was provided by phone, the tissue viability nurse did not come into the approved centre to assess the residents.

Of the six files inspected two residents in St. Aidan's Ward were overdue their six monthly general health checks. In Grangemore ward, the six-monthly general health assessment was not adequately completed. Full records were not available demonstrating residents' completed general health checks and associated results, including records of any clinical testing.

The approved centre was compliant with Part 4 of the Mental Health Act 2001.

Respect for residents' privacy, dignity and autonomy

Grangemore ward had a mixture of four bedded rooms and single bedrooms. St. Aidan's ward consisted of two dormitory bedrooms and single bedrooms. One dormitory bedroom had five beds. The other had eight beds and both male and females shared this dormitory. While observation panels on doors of treatment rooms and bedrooms were fitted with blinds, the blinds were left open by default and residents did not have access to a control mechanism to open or close these. Residents wore their own clothes and had control over their property. Residents could meet visitors in a private setting and could freely communicate externally. CCTV did not compromise the residents' dignity.

In two episodes of physical restraint, a same sex staff member was not present during the physical restraint episode. Instead, two members of the opposite sex to the resident were present during these two episodes. Mechanical restraint was used in the form of lapbelts for the safety of some residents and was compliant with the relevant Rule.

Responsiveness to residents' needs

There was a range of recreational activities available. The approved centre offered residents from Grangemore ward access to a number of garden areas, but the external garden in St. Aidan's ward was not readily available due to its location and because of staffing shortages. Access to this external garden area required the availability of staff to supervise.

The approved centre was not clean, and some toilets throughout the approved centre were malodourous. The approved centre was kept in a poor state of repair. Wall paint was peeling and damaged, and the floor covering in some areas was damaged. There was no programme of planned general maintenance. There was a sufficient number of toilets and showers for residents in Grangemore ward but not in St. Aidan's ward. Nine male residents in St. Aidan's had the use of a single toilet.

Information was available verbally and in written form about the approved centre, medication, and diagnoses.

Governance of the approved centre

The approved centre was part of the South East Community Health Care (previously known as CHO 5). It was governed by the Waterford/Wexford Mental Health Services Executive Management Team. This committee met monthly and minutes from these meetings were made available to the inspection team.

There was a Waterford/Wexford Mental Health Services Quality and Safety Executive Committee which met monthly. A Quality Patient Safety Committee (QPSC) for St. Otteran's had been developed since the last inspection. This committee reported directly to the Waterford/Wexford Mental Health Services Quality and Safety Executive Committee. The reviewed minutes from this committee indicated a robust agenda, including actions where applicable and by whom. A Clinical Director had been appointed since the last inspection.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre established a Quality Patient Safety Committee, which in turn reported to the wider Waterford/Wexford Mental Health Services Executive Management Team meetings.

2. Dog Therapy was introduced in the approved centre since the last inspection as a new recreational activity.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

St. Otteran's Hospital was located in the suburbs of Waterford. It was divided into two wards, Grangemore ward and St. Aidan's ward. Each ward functioned separately from the other and were managed by two separate Assistant Directors of Nursing. Grangemore ward was under the care of the rehabilitation and recovery team, and St. Aidan's ward was under the care of the psychiatry of old age team and the rehabilitation and recovery team.

Grangemore ward had 16 beds with an occupancy of 15 and St. Aidan's ward had 24 beds with an occupancy of 14 at the time of inspection. Grangemore had a mixture of four bedded rooms and single bedrooms. St. Aidan's ward consisted of two dormitory bedrooms and single bedrooms. One dormitory bedroom had five beds. The other had eight beds and both male and females shared this dorm.

Both wards were in need of refurbishment and there was no programme of planned general maintenance in the approved centre.

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

Resident Profile	
Number of registered beds	***40***
Total number of residents	**29**
Number of detained patients	1
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	29
Number of patients on Section 26 leave for more than 2 weeks	0

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 part of the South East Community Health Care (SECH), previously known as CHO 5. It was governed by the Waterford/Wexford Mental Health Services Executive Management Team. This committee met monthly and minutes from these meetings were made available to the inspection team.

There was a Waterford/Wexford Mental Health Services Quality and Safety Executive Committee which met monthly. Minutes for these meetings were also made available to the inspection team. A Quality Patient Safety Committee (QPSC) for St. Otteran's had been developed since the last inspection. This committee reported directly to the Waterford/Wexford Mental Health Services Quality and Safety Executive Committee. QPSC had being meeting monthly since June 2018. The reviewed minutes from this committee indicated a robust agenda, including actions where applicable and by whom.

During this inspection most of the heads of discipline met with the Inspectorate. However, social work was unavailable to meet with the inspectorate. The heads of discipline provided information about the governance processes of the approved centre. Issues of concern included staff shortages and the seeking of a locum consultant for the consultants cover.

A Clinical Director had been appointed since the last inspection.

4.5 Use of restrictive practices

Physical restraint and mechanical restraint had been used since the last inspection. There were two entrances into Grangemore ward. The main entrance was locked to help facilitate close observation of a resident. However, residents still had unrestricted access to enter and exit the ward by using the second entrance door.

5.0 Compliance

5.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 5: Food and Nutrition	✓		✗	Moderate	✗	High
Regulation 7: Clothing	✓		✓		✗	Moderate
Regulation 16: Therapeutic Services & Programmes	✓		✗	High	✗	High
Regulation 18: Transfer of Residents					✗	Moderate
Regulation 19: General Health	✗	Moderate	✗	Critical	✗	High
Regulation 21: Privacy	✓		✗	Moderate	✗	High
Regulation 22: Premises	✓		✗	Moderate	✗	High
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines	✓		✓		✗	Moderate
Regulation 26: Staffing	✗	High	✗	Critical	✗	High
Regulation 28: Register of Residents	✗	High	✗	Low	✗	High
Regulation 31: Complaints	✓		✓		✗	Moderate
Code of Practice on the use of Physical Restraint in Approved Centres	✗	Moderate	✗	Low	✗	Moderate
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Moderate

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.

5.2 Areas of compliance rated "excellent" on this inspection

No areas of compliance were rated excellent on this inspection.

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

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 to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents 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 Area Lead from the HSE Mental Health Engagement Office was contacted.

With the residents' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

One resident met with the inspectorate. The resident stated that sometimes other residents smoked in the pool room area in the ward. The resident goes on supervised outings, but sometimes this was unable to happen due to staff shortages. The resident was satisfied with the living space and the quality and choice of food.

Fourteen questionnaires were completed by residents, families, and advocates and returned to the inspectorate.

Issues raised included lack of knowledge or involvement in individual care plans, lack of access to adequate activities during the day, lack of clarity regarding the identity of keyworkers, and uncertainty regarding the procedure to raise complaints. A number of concerns were raised regarding lack of adequate space for privacy.

The area advocate met with the inspectorate. No problems or issues of concerns were voiced.

7.0 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:

- Acting Area Director of Nursing
- Psychology Manager
- Occupational Therapy Manager
- Senior Register
- Acting Director of Nursing
- Consultant Psychiatrist
- Clinical Nurse Manager 1
- Service Manager
- Clinical Nurse Manager 2 x 2
- Executive Clinical Director

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.

Clarification was provided to the inspectorate team on numerous topics. These included that funding for GP access for St. Aidan's ward was under negotiation. The approved centre are looking for a GP who will attend St. Aidan's ward for two to three sessions per week. Pressure sore guidelines were being developed.

The current staff shortages are impairing the approved centres ability to arrange training. Staff training was based on available resources and on the good will of staff coming in for the training on their day off.

8.0 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

COMPLIANT

Quality Rating **Satisfactory**

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 had a written policy in relation to the identification of residents, which was last reviewed in April 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The identifiers, detailed in residents' clinical files, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The identifiers used were person-specific and appropriate to the residents' communication abilities. There was a red sticker alert system in place on clinical files to help staff in distinguishing between 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 training and education and monitoring pillars.

Regulation 5: Food and Nutrition

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 food and nutrition, which was last reviewed in July 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate 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 to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Hot and cold drinks were offered to residents routinely five times a day and by request.

The Malnutrition Universal Screening Tool (MUST), which was an evidence-based nutrition assessment tool was used for residents with special dietary requirements. Their nutritional and dietary needs were not always assessed, where necessary, and addressed in residents' individual care plans. While residents in Grangemore ward could access a dietician on a referral basis from their own GP to have their special dietary needs assessed, residents in St. Aidan's ward could not. Specifically, in St. Aidan's ward, there was no access to a dietitian for residents with special dietary requirements who were unable to access dietetic services externally.

The approved centre was non-compliant with this regulation as it did not ensure that residents with special dietary requirements living in St. Aidan's ward were assessed by a dietitian to ensure their nutritional and dietary needs were met, 5 (1).

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(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. The policy included the requirements of the *Judgement Support Framework* with the exception of the food preparation, handling, storage, distribution, and disposal controls.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was suitable and sufficient catering equipment in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Appropriate hand-washing areas were provided for catering services. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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 monitoring pillars.

Regulation 7: Clothing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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 had a written policy in relation to residents' clothing, which was last reviewed in April 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy on residents' clothing. Relevant staff interviewed were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. No current residents were prescribed to wear nightwear during the day.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. They had an adequate supply of individualised clothing. Residents were not provided with any emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. There were old pyjamas and other clothes which had been washed, some of which had previously belonged to people who had died. While residents were provided with disposable underwear, there was no new emergency underwear in stock. The approved centre had access to a fund to buy clothes for residents when needed.

The approved centre was non-compliant with this regulation because the approved centre did not provide an adequate and appropriate supply of suitable clothing for emergency situations, 7 (1).

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

(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 had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in May 2018. The policy addressed all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safekeeping of the residents' monies, valuables, personal property, and possessions, as necessary. At the time of the inspection, all residents had their own lockers and presses to safeguard their own property. Monies were transferred to the main hospital finance office.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis, in accordance with the approved centre's policy.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff and the resident or their representative.

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 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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 June 2018. The policy included the requirements of the *Judgement Support Framework* with the exception of the facilities available for recreational activities, including the identification of suitable locations for recreational activities within and external to the approved centre.

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities, including a log of resident attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. The resident information booklet given to residents provided detailed, accessible, and user-friendly information on recreational activities, including the type and frequency of recreational activities. The timetable for activities was displayed on noticeboards in the approved centre.

Activities included access to a smart TV, music, newspapers, gardening, a therapy dog, and age and capacity appropriate films and music. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre offered residents from Grangemore access to a number of garden areas, but the external garden in St. Aidan's was not readily available due to its location and because of staffing shortages. Access to this external garden area required the availability of staff to supervise.

The approved centre had occupational therapy input. Communal areas provided were suitable for recreational activities. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Systematic records of resident attendance at events were not maintained in group records or in the clinical files.

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 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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. The policy included all of the requirements of the *Judgement Support Framework* with the exception of the process of respecting a resident's religious beliefs during the provision of services, care, and treatment.

Training and Education: Relevant staff had signed the signature log to indicate 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 to support residents' religious practices was not reviewed since the last inspection, to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Residents had access to multi-faith chaplains. The Church facility in the approved centre was closed and not used. Religious services were held at intervals in the approved centre. A Roman Catholic Minister of the Eucharist attended the approved centre weekly.

It was possible for residents from Grangemore to attend external local religious services, if deemed appropriate following a risk assessment. Residents were facilitated to observe or abstain from religious practice in accordance 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 processes and monitoring pillars.

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

(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. The policy included the requirements all of the *Judgement Support Framework* with the exception of the required visitor identification methods.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: There were no restrictions on residents' rights to receive visitors. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed and were documented at the entrance to both wards and internally throughout the approved centre. The times were appropriate, reasonable, and flexible, and were also detailed within the resident information booklet.

A separate visitors' room and visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Residents could meet visitors in visiting rooms in St. Aidan's ward. Residents in Grangemore ward could use communal areas, their own room, or external areas. Where appropriate, residents were able to leave the premises with visitors.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly on noticeboards throughout the approved centre. The visiting room, areas, and facilities available 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 and monitoring pillars.

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

(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 operational policy in relation to resident communication, which was last reviewed in January 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: There were no restrictions on residents' communication at the time of the inspection.

Evidence of Implementation: Residents could use mail, fax, a cordless phone, and their own mobile phone if they wished. Residents in both wards had access to the internet.

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 13: Searches

COMPLIANT

(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 operational policy in relation to the implementation of resident searches, which was last reviewed in May 2018. The policy addressed 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 is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

The policy did not include the processes for communicating the approved centre's search policies and procedures to residents and staff.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy on searches. Relevant staff were able to articulate the searching processes as set out in the policy.

There were no searches conducted in the approved centre since the last inspection. Therefore, the approved centre was assessed under the two pillars of processes and training and education only.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

(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 operational policy in relation to care of the dying, which was last reviewed in July 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: End of life care provided to residents was not systematically reviewed to ensure section 2 of the regulation had been complied with. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: One resident had died in expected circumstances in the approved centre since the last inspection, and their clinical file was inspected. Advance directives relating to end of life care, including *Do Not Attempt Resuscitation Orders* and associated documentation, were evidenced in the clinical file. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of the resident, who was cared for in a single room.

Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Pain management was prioritised and managed during end of life care. Support was given to other residents and staff following the resident's death. The coroner was notified of the death. All deaths of residents were 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 training and education and monitoring pillars.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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 had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Residents' ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence Of Implementation: All residents in the approved centre at the time of the inspection were long-term residents. Each resident had an ICP, ten of which were inspected. All ICPs were a composite set of documentation detailing goals, treatment, care, and resources required. The documentation stored within each resident's clinical file was identifiable, uninterrupted, and not amalgamated with progress notes.

Each resident had been assessed at admission by the admitting clinician and an initial ICP was developed. The ICPs were then developed by the MDT following a comprehensive assessment, within seven days of admission. Evidence-based assessments were used. A key worker was identified to ensure continuity in the implementation of a resident's ICP.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs identified appropriate goals, care and treatment, and interventions and specified the resources required to provide the care and treatment identified. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances, and goals; this was documented every six months.

The residents had access to their ICPs and were kept informed of any changes. Residents were offered a copy of their ICPs, including any reviews, and this was documented. When a resident declined or refused a copy of their ICP, this was recorded, including the reason, if given.

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 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

(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, which was last reviewed in June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence Of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based. A timetable of all therapeutic services and programmes provided in the approved centre was available to residents in St. Aidan's ward but not to residents in Grangemore ward. Adequate facilities were available to provide therapeutic services and programmes. Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies. Therapeutic spaces included a therapy kitchen, a church hall, and an activation and therapy unit.

Therapeutic programmes and services were insufficient and were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents living at St Aidan's Ward. The programmes offered to residents were not varied, and were narrow in scope. All residents in St. Aidan's ward were offered dog therapy and garden therapy only, and they had access to 0.4 (whole time equivalent) of an occupational therapist. There was no one-to-one occupational therapy sessions.

Residents in Grangemore ward had access to c. 0.2 WTE (whole time equivalent) of an occupational therapist and these residents were provided with a more varied range of therapeutic services than St. Aidan's residents. Activities in Grangemore included one-to-one occupational therapy sessions, arts and crafts groups, various exercise and activity groups, and a kitchen skills group, which included a baking group.

In relation to psychology, there was psychology input on the rehabilitation and recovery team only. All residents living at Grangemore were under the rehabilitation and recovery service, and psychology input was on a one-to-one basis. Two residents living at St. Aidan's were under the rehabilitation and recovery service and therefore had access to psychology services if required. A record was maintained of

participants, engagement, and outcomes achieved in therapeutic services or programmes within each resident's clinical file.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. Programmes were not of adequate variety. 16 (2).

Regulation 18: Transfer of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 and procedures in relation to the transfer of residents, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A log of transfers was maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented 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 had been transferred from the approved centre was examined. The resident was risk assessed prior to the transfer. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. Their agreement to receive the resident in advance of the transfer was documented.

Communication records with the receiving facility were documented. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks. There was no documented record to indicate the resident's accompaniment requirements on transfer. Documented consent of the resident's consent to being transferred was not evidenced.

Written information was issued as part of the transfer, this included the resident transfer form and the required medication for the resident during the transfer process. The written information issued did not include a letter of referral.

A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process, including a copy of the letter of referral, and the resident transfer form were not retained in the residents' clinical file.

The approved centre was non-compliant with this regulation because it did not ensure that all relevant information about the resident was provided to the receiving health care facility, 18(1).

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in May 2018. The policies and procedures included the requirements of the *Judgement Support Framework* with the following exceptions:

- The management, response, and documentation of a medical emergency, including cardiac arrest.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policy.

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: Staff in the approved centre called the ambulance when emergencies occurred. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator. The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Adequate arrangements were not in place for residents to access general health services and be referred to other health services, as required. The six clinical files inspected showed that not all residents received appropriate general health care interventions in line with their individual care plans. Residents in Grangemore had access to a community GP when required, but residents in St. Aidan's ward did not have access to a GP. Instead, the non-consultant hospital doctor assessed the resident's in St. Aidan's on admission, and when issues arose. There was no on-going medical monitoring of residents' general health needs. Residents in St. Aidan's did not have access to a dentist for regular dental health checks.

Residents had inadequate access to the Tissue Viability Nurse in St. Aidan's ward. There was evidence that residents were getting grade two pressure ulcers which were being referred to the Tissue Viability Nurse. While nursing advice in relation to pressure ulcers was provided by phone, the tissue viability nurse did not

come into the approved centre to assess the residents. Only eight nurses had been trained in the management of pressure ulcers, three more since the last inspection. A number of residents required full assistance with all tasks of daily living and remained in bed all day putting them at higher risk of developing pressure ulcers.

Resident's general health needs were not monitored and assessed at least every six months. Of the six files inspected two residents in St. Aidan's Ward were overdue their six monthly general health checks. In Grangemore ward, while files inspected showed that these three residents had received a six-monthly general health assessment, the assessment itself was not adequately completed.

All six files inspected evidenced that each of the six residents had received a physical examination. The six-monthly general health assessment records evidenced the following discrepancies on inspection:

- Family personal history was not documented in three cases.
- Residents Body Mass Index was not consistently checked and recorded.
- None of the six residents received an assessment of their waist circumference.
- Smoking status was not documented in three cases.
- Nutritional status (diet and physical activity, including sedentary lifestyle) was not documented in three cases.
- Dental health assessments were not documented. Residents in St. Aidan's ward did not have regular access to a dentist. On one occasion a dentist did visit a resident with dental problems in St. Aidan's ward, but regular dental reviews were not undertaken.

Full records were not available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Instead, incomplete records were available.

For residents on antipsychotic medication, they received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels. Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre which included retina check (diabetics only), and bowel screening.

There was no formal smoking cessation programme in the approved centre, though residents were encouraged to cease smoking on both wards. Staff had access to smoking cessation supports e.g. nicotine patches, if required, however no current resident was being supported to stop smoking.

The approved centre was non-compliant with this regulation because:

a) **Adequate arrangements were not in place for access by residents in St. Aidan's Ward to a GP service and tissue viability nurse, 19 (a).**
b) **The six-monthly general health assessment records and associated tests were not fully complete, 19 (b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

(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 had a written operational policy and procedures in relation to the provision of information to residents, which was last reviewed in May 2018. The policy addressed the requirements of the *Judgement Support Framework*, with the exception of the process for identifying residents' preferred ways of receiving and giving information.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

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

Evidence of Implementation: Residents were provided with an information booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. At the time of the inspection there were no restrictions on information regarding a resident's diagnosis, applied to any resident.

Medication information sheets, as well as verbal information, were provided in a format appropriate to the resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services when needed.

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 monitoring pillars.

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2015. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

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

Monitoring: A documented annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre 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 called by their preferred name. The general demeanour of staff and the way in which staff addressed and spoke with residents was respectful. Residents were wearing clothes which respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

Rooms were not overlooked by public areas. While observation panels on doors of treatment rooms and bedrooms were fitted with blinds, the blinds were left open by default and residents did not have access to a control mechanism to open or close the blinds. This meant resident's privacy and dignity in bedroom areas was not appropriately respected and maintained at all times.

The approved centre was non-compliant with this regulation due to its failure to ensure the privacy of all bedrooms and therefore, resident's privacy and dignity was not appropriately respected at all times.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in July 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised. Ligature point risks were minimised. Residents in St. Aidan's did not have sufficient access to outdoor spaces including external gardens, as access was locked unless staff were specifically available to accompany and supervise residents outside.

While there was a cleaning schedule implemented, the approved centre was not clean, hygienic, and free from offensive odours. Some toilets throughout the approved centre were malodourous. The approved centre was kept in a poor state of repair. Wall paint was peeling and damaged, and the floor covering in some areas was damaged. There was no programme of planned general maintenance. Maintenance was reactive to specific requests. A log of maintenance requests was maintained. Back-up power was available in the approved centre.

Resident bedrooms were appropriately sized to address the resident needs. Suitable facilities were not provided to support resident independence and comfort. There was a sufficient number of toilets and

showers for residents in Grangemore ward but not in St. Aidan's ward. Nine male residents in St. Aidan's had the use of a single toilet. For clinical reasons one resident required dedicated use of one out of a total of two toilets on the ward.

Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to the implementation for possible impact on current residents and staff. The Mental Health Commission was informed prior to the commencement of works. Remote or isolated areas of the approved centre were monitored.

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

a) **The premises were not maintained in good decorative condition throughout the approved centre, 22, 1 (a).**
b) **A programme of routine renewal of the fabric, and decoration of the premises was not developed, implemented, or documented, 22, 1 (c).**
c) **The registered proprietor did not ensure that an approved centre has adequate and suitable facilities having regard to the number and mix of residents in the approved centre. There was an inadequate number of toilets for the male residents in St. Aidan's ward, 22 (3).**

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(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.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: No medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Not all nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policy and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and ten- of these were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, and details of dosage, and frequency of medication. However, two out of ten MPARs inspected did not have micrograms written in full, instead the abbreviation mcg was detailed. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR. A record was kept when medication was refused by or withheld from the resident.

While the administration route for the medication was written in all MPARs, four out of ten MPARs did not detail a record of all medications administered to the resident. All of these four MPARs related to residents in St. Aidan's ward. Some gaps were evidenced on these four MPARs, and there was no code entered to say that the resident was on leave.

All entries in the MPAR were legible, and written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration; and expired medications were not administered. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition. This was documented in the resident's clinical file.

All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members prior to administration. The

use of appropriate resident identifiers, good hand-hygiene techniques, and cross-infection control techniques were observed during the administration of medication.
Medication was stored in the appropriate environment, as advised by the pharmacist. Refrigerators used for medication were used only for this purpose, but a daily log was not completed of fridge temperatures in Grangemore ward. Food and drink was not stored in areas used for the storage of medication. The medication trolley remained locked at all times and secured in a locked room.

An inventory of medications was conducted on a monthly basis, checking the name, dose, and expiry date of medication but the quantity of medication was not checked. The quantity of some medications was above the levels required for administration.

In accordance with Regulation 23(1), the approved centre was non-compliant as the registered proprietor did not ensure that the approved centre has suitable practices relating to the prescribing and administration of medicines for the following reasons:

a) **Four out of ten MPARs did not detail a record of all medications administered to the resident.**
b) **Two out of ten MPARs did not have micrograms written in full.**

Regulation 24: Health and Safety

COMPLIANT

(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 a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The policy was reviewed in March 2016. The policy addressed requirements of the *Judgement Support Framework* with the exception of infection control measures in relation to linen handling, responding to sharps or needle stick injuries, and specific infection control measures in relation to infection types, e.g. C. diff, MRSA, and Norovirus.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

Evidence of Implementation: This Regulation 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

COMPLIANT

Quality Rating **Satisfactory**

(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

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in June 2016. The policy addressed requirements of the *Judgement Support Framework* with the exception of the maintenance of CCTV cameras by the approved centre.

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

Monitoring: The quality of the CCTV images was not checked regularly to ensure that the equipment was operating appropriately. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence Of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe a resident were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. The Mental Health Commission had been informed about the approved centre's use of CCTV.

The approved centre was compliant with this regulation. The quality was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and monitoring pillars.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 and procedures in relation to its staffing requirements, which was last reviewed in April 2016. The policy and procedures addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- Staff performance and evaluation requirements.
- Staff rota details and the methods applied for their communication to staff.
- The process for transferring responsibility from one staff member to another.

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

Monitoring: The implementation and effectiveness of the staff training plan were reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place which illustrated the leadership and management structure and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the approved centre's policy and procedures for recruitment, selection, and appointment.

Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff and there were definite support mechanisms in place. This included tuition support, scheduled time away from work, or recognition for achievement.

The numbers and skill mix of staffing was inadequate to meet residents' needs, and the size and layout of the approved centre. Staff shortages were attempted to be mitigated by using agency staff, staff overtime, and by moving staff from services within the Waterford and Wexford Mental Health Services. Despite this, rosters evidenced that the approved centre did not always have the registered numbers of staff required on duty each day.

A written staffing plan was not available within the approved centre. Staff were not trained in line with the assessed needs of the resident group profile and of individual residents. Not all staff were trained in wound care, dementia care, risk management and treatment, and incident reporting. Staff were not trained in manual handling, infection control and prevention (including sharps, hand-hygiene techniques, and use of personal protective equipment), end of life care, recovery-centred approaches to mental health care and treatment, resident rights, caring for residents with an intellectual disability, and the protection of children and vulnerable adults.

Not all health care staff were trained in the following:

- fire safety
- Basic Life Support
- Management of violence and aggression
- The Mental Health Act 2001.

Staff were trained in Children First. All staff training was documented and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre:

Ward or Unit	*Staff Grade*	*Day*	*Night*
Grangemore Ward	CNM2	1	1
	RPN	5	2
	HCA	0	0
	Occupational Therapist	0.2	

Ward or Unit	*Staff Grade*	*Day*	*Night*
St. Aidan's Ward	CNM2	1	0
	RPN	4	3
	HCA	1	0
	Occupational Therapist	0.4	

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

Social work: On referral basis

Psychology : On referral basis

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

a) **Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, and the management of violence and aggression, 26(4).**
b) **Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**

c) **The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, and the size and layout of the approved centre, 26 (2).**

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

(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.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

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 a written policy and procedures in relation to the maintenance of records, which was last reviewed in May 2018. The policy addressed requirements of the *Judgement Support Framework* with the exception of the record review requirements.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff were trained in best-practice record keeping.

Monitoring: Not all resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Resident records were reflective of the residents' current status and the care and treatment being provided. Records had no loose pages. Resident records were physically stored together. All residents' records were secure, up to date, constructed, maintained, and used in accordance with national guidelines and legislative requirements. Records were developed and maintained in a logical sequence. Resident records were maintained using two identifiers which were unique to the resident.

Only authorised staff made entries in residents' records, or specific sections therein. Hand-written records were legible and written in black indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre. Residents' access to their records was managed in accordance to the Data Protection Acts.

The approved centre was compliant with this regulation. The quality 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 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 admitted. The register was not up-to-date. The register contained the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006 with the following exceptions: diagnosis on admission, diagnosis on discharge, discharge date, and resident status (voluntary or involuntary) were not consistently recorded.

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

a) **The register was not up-to-date.**
b) **The register did not include all of the information specified in Schedule 1 to these Regulations:**
   - **Diagnosis on admission not consistently recorded.**
   - **Diagnosis on discharge was not consistently recorded.**
   - **Discharge date was not consistently recorded.**
   - **Resident status, i.e. voluntary or involuntary, was not consistently recorded.**

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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 in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in June 2017. It included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for disseminating operating policies and procedures, either in electronic or hard copy.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The standardised operating policy and procedure layout used by the approved centre.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could 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 of developing and reviewing policies.

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines. The format of the operating policies and procedures was standardised. Any generic policies used were appropriate to the approved centre and the resident group profile.

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 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

(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

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals, which was last reviewed in June 2018. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend their Mental Health Tribunal as 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 monitoring pillar.

Regulation 31: Complaints Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 operational policy and procedures in place in relation to the management of complaints, which was last reviewed in May 2018. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. Not all staff had signed the signature log to indicate 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: Audits of the complaints log and related records had not been documented or completed. Complaints data was analysed for senior management to consider at monthly QSEC meetings. Details of the analysis were considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence Of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed on noticeboards in the approved centre, and it was detailed within the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

There were no formal complaints lodged and no minor complaints were escalated since the last inspection. All complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. There was no documented evidence to indicate that all minor complaints were investigated promptly. Complaint handling timeframes, actions, or outcomes were not consistently recorded in the minor complaints log in Grangemore ward.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all complaints and the results of any investigations, and any actions taken on foot of a complaint were fully and properly recorded, 31 (7).

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

(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 and incident management procedures, which was last reviewed in May 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Not all clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had not been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk, the risk manager, was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and mechanical restraint, and at resident admission and transfer. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were removed or effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The risk manager reviewed incidents for any trends or patterns occurring in the service.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan 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 training and education and monitoring pillars.

Regulation 33: Insurance

COMPLIANT

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 covered by 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

COMPLIANT

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. The certificate was displayed prominently in the reception area.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

COMPLIANT

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 two residents who had been mechanically restrained were inspected. The approved centre complied with Part 5 of the Rules Governing the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others, across both episodes.

Mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need, and it was only used when less restrictive alternatives were not suitable. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist acting on his/her behalf.

Each clinical file contained a contemporaneous record that specified the following:

- That there was an enduring risk of harm to self or to others.
- That less restrictive alternatives were implemented without success.
- The type of mechanical restraint.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The approved centre was compliant with this rule.

10.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 Consent to Treatment

COMPLIANT

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

The clinical file of one detained (i.e. involuntary) patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication for over three months was examined. The patient was unable to consent to receiving treatment and this was documented.

A *Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* had been appropriately completed. It included details of the discussions with the patient on the nature and purpose and the effects of the medication. Any views expressed by the patients were recorded. Authorisation was provided by a second consultant psychiatrist. An assessment of the patient's ability to consent to treatment had been completed.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

11.0 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.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in May 2018. The policy addressed the following:

- The provision of information to the resident.
- Those who can initiate and implement physical restraint.
- Staff who receive training in the use of physical restraint.
- Areas addressed within the training programme.
- The frequency of training.
- The identification of appropriately qualified personnel to deliver training.
- The mandatory nature of training for those involved in physical restraint.
- That physical restraint should never be used to ameliorate staff shortages.

Training and Education: Not all staff had signed a log to indicate that they had read and understood the physical restraint policy. A record of staff attendance at training was not maintained.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: Three physical restraint episodes in relation to two residents were inspected. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all cases, the restraint order lasted for a maximum of 30 minutes.

The registered medical practitioner completed a physical examination of each resident within three hours after the start of an episode of physical restraint. One of the two residents was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was documented. In all three episodes, the resident's next of kin was informed about the physical restraint.

In two of the three episodes of physical restraint a same sex staff member was not present during the physical restraint episode. Instead, two members of the opposite sex to the resident were present during these two physical restraint episodes. The reason was a same sex staff member was not available.

Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. Where appropriate, residents discussed the episode with members of the MDT as soon as was practicable. All uses of physical restraint were clearly recorded in the clinical practice forms detailed and recorded within clinical files.

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

a) **The approved centre did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy, 9.2 (b).**
b) **A record of attendance at training was not maintained. 10.2.**
c) **In two of the three episodes of physical restraint a same sex staff member was not present during the physical restraint episode, instead two members of the opposite sex to the resident was present during these two physical restraint episodes. 6.3.**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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 written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in August 2015, the transfer policy was last reviewed in May 2018, and the discharge policy was last reviewed in May 2018. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the transfer policy. Not all relevant staff had signed to indicate that they had read and understood the admission and discharge policies.

Monitoring: Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation: The admission, transfer, and discharge processes were compliant under Regulation 32: Risk Management Procedures, which is associated with this code of practice.

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident was supported either by a family member, carer, or advocate in the admission process, with the resident's consent. The resident received an admission assessment which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the MDT and the resident's family. A comprehensive pre-discharge assessment was completed; which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent within three days to the relevant service. A comprehensive discharge summary was issued within 14 days to relevant personnel. The discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up

arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was non-compliant with this code of practice because:

a) **Not all relevant staff had signed to indicate that they had read and understood the admission and discharge policies, 9.1.**
b) **Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies, 4.19.**

Appendix 1: Corrective and Preventative Action Plan Template - 2018 Inspection Report

Regulation 5: Food and Nutrition

Report reference: Page 18

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. The Approved Centre did not ensure that residents with special dietary requirements living in St. Aidan's ward were assessed by a dietitian to ensure their nutritional and dietary needs were met, 5 (1).	*New*	Corrective Action(s): Service Manager will explore all options of outsourcing dietetic review by private providers for residents with special dietary requirements as a matter of priority. Post-Holder(s) responsible: Service Manager	Oversight through the ICP process and audit	Achievable	End of Q2 2019
		Preventative Action(s): In future when a primary nurse identifies that a resident has a special dietary requirement, he/she will inform the Clinical nurse manager who will liaise with the service manager in order to secure a dietetic review by a private provider. Post-Holder(s) responsible: Primary Nurse/Clinical Nurse Manager	Oversight through the ICP process and audit	Achievable	Ongoing

Regulation 7: Clothing

Report reference: Page 20

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
2. The Approved Centre did not provide an adequate and appropriate supply of suitable clothing for emergency situations, 7 (1).	*New*	Corrective Action(s):A supply of new emergency clothing was purchased on Saturday 19th January 2019 Post-Holder(s) responsible: Clinical Nurse Manager	On a six monthly basis the Clinical Nurse Manger will review the supply of emergency clothing on the unit	Achievable	Complete
		Preventative Action(s): In future the CNM will carry out a stock review of emergency clothing on a six monthly basis and arrange that replacement clothing be purchased as required from Shaws department store where there is an established HSE clothing account for this specific purpose. Post-Holder(s) responsible: Clinical Nurse Manager	On a six monthly basis the Clinical Nurse Manger will review the supply of emergency clothing on the unit	Achievable	Ongoing

Regulation 16: Therapeutic Services and Programmes

Report reference: Pages 30 & 21

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. The Approved Centre did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. Programmes were not of adequate variety. 16 (2).	*New*	Corrective Action(s): Since October 2018 the Poole Activity Level (PAL) Assessment has been incorporated in the ICP for all POLL residents in St. Aidan's. A timetable has been put in place for Grangemore of the available occupational therapy programmes running on the unit. A therapeutic Programmes MDT working group has been established for St. Aidan's. This group will be responsible for developing and monitoring the therapeutic programme and highlighting any issues with the roll out of therapeutic programmes in St. Aidans. Post-Holder(s) responsible: Occupational Therapy	Completed PAL assessments in each service users healthcare record. PAL goals recorded in the service users ICP. Copy of time table is on display in Grangemore, additional copies available from OT Once developed for St. Aidan's, the therapeutic programmes timetable and records of participation will be available for review. Oversight by the QPSC meetings.	Achievable Achievable Achievable	Completed Completed End Q 1 2019.
		Preventative Action(s): A therapeutic Programmes MDT working group has been established for St. Aidan's. This group will be responsible for developing and monitoring the therapeutic programme and highlighting any issues with the roll out of therapeutic programmes in St. Aidans.	Feedback from the group will be sent to the QPSC.	Achievable	End of January 2019

		Funding for additional occupational therapy staffing has been allocated to support the implementation of therapeutic programmes in St. Aidans and Grangemore. This resource will provide 14 hours additional occupational therapy input per week to the St. Otteran's campus. A candidate for this post has been identified via a locum agency. A provisional start date of 19th March 2019 has been suggested to this therapist. The OT manager is awaiting a formal response from the candidate in relation to this start date. Post-Holder(s) responsible: Occupational Therapy	This will be monitored through the QPSC meetings	Achievable	March 2019

Regulation 18: Transfer of Residents

Report reference: Page 32

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. The Approved Centre did not ensure that all relevant information about the resident was provided to the receiving health care facility, 18(1).	New	Corrective Action(s): The Assistant Director of Nursing has sent a memo on 18th January 2019 to to nursing staff involved in transfer of patients to remind them of the requirements under Regulation 18 and Code of Practice and the importance of retaining a copy of all transfer documents in the patient's HCR. Post-Holder(s) responsible:Assistant Director of Nursing	Audit post transfer of resident by the CNM2	Achievable	Completed. Memo sent 18th January 2019
		Preventative Action(s): Current transfer checklist will be updated by QPSC to include the requirements of documenting consent to Transfer. Post-Holder(s) responsible:QPSC	Audit post transfer of resident by the CNM2	Achievable	End Q1 2019

Regulation 19: General Health

Report reference: Pages 33 & 34

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
5. Adequate arrangements were not in place for access by residents in St. Aidan's Ward to a GP service and tissue viability nurse, 19 (a).	*New*	Corrective Action(s):The Deputy Hospital Manager has made contact with GPs in Waterford city seeking to ascertain their interest in providing a General Practice service to St. Aidans unit. To date no GP has given a definitive commitment to providing this service. Negotiations are ongoing with potential interested parties. Pressure ulcer prevention protocol was put in place in Quarter 4 2018. Similarily, SSKIN bundle assessment has been formally implemented in St. Aidans ward. An RPN due to graduate as a TVN in September 2019 for WWMHS Post-Holder(s) responsible:Service Manager/Area Director of Nursing/ADoN/CNM	Review through QPSC monthly	Funding secured however there is difficulty recruiting GP services for St Aidans Unit. Negotiations remain ongoing Achievable	Review through QPSC monthly End September 2019
		Preventative Action(s): An RPN is currently completing a Post-Graduate Diploma in Tissue Viability. This educational intervention has been funded by the Nursing and Midwifery Planning and Development Unit and should provide the Waterford/Wexford MHS with appropriate expertise in the area of wound management. Post-Holder(s) responsible: Service Manager/Area Director of Nursing/ADoN/CNM	Review through MDT meeting	Review of patients physical health will continue to be monitored by NCHD until GP services have been secured. Achievable	Ongoing September 2019

6. The six-monthly general health assessment records and associated tests were not fully complete, 19 (b).	*Reoccurring*	Corrective Action(s): All six month general health assessments and associated tests were completed once this deficit was identified by the investigation team. Post-Holder(s) responsible: NCHD	Flagging system is now in place to identify those residents whose general health assessments and associated tests are due. The key worker will communicate this to the medical team	Achievable	Completed
		Preventative Action(s): A flagging system has been developed and implemented whereby the primary nurse and/or CNM will communicate to the NCHD on the team the date that individual residents six monthly general health assessments are due. This flagging system is evidenced by the implementation of a ward diary in which dates for six monthly physical reviews are recorded and co-ordinated under the supervision of the CNM. Post-Holder(s) responsible:Primary nurse/CNM/NCHD	Flagging system is in place to identify those residents whos assessments and associated tests are due and the primary nurse/CNM will communicate this to the medical team	Achievable	Completed Monitoring is Ongoing

Regulation 21: Privacy

Report reference: Page 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
7. Failure to ensure the privacy of all bedrooms and therefore, resident's privacy and dignity was not appropriately respected at all times.	*Reoccurring*	Corrective Action(s): The CNM on St. Aidans ward has committed to liaising with the Technical Services Department in UHW to repair or replace the faulty blind which was noted by the inspection team. Post-Holder(s) responsible:CNM/ADoN	Oversight by the QPSC	Achievable	End Q 1 2019
		Preventative Action(s): The CNMs on St. Aidans and Grangemore wards will conduct a walk around on a quarterly basis to identifiy any issues which may impact on the services ability to respect residents' privacy and dignity . Post-Holder(s) responsible: CNM/ADoN/QPSC	Walkarounds will be recorded in the ward diary Oversight by the QPSC	Achievable	Ongoing

Regulation 22: Premises

Report reference: Pages 38 & 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
8. The premises were not maintained in good decorative condition throughout the approved centre, 22, 1 (a).	*Reoccurring*	Corrective Action(s):Funding approved by Service Manager for the purchase of new floor covering and for the painting of Grangemore. Post-Holder(s) responsible: Service Manager/CNM/Technical Services Dept	Oversight by the QPSC	Achievable	Ongoing
		Preventative Action(s): Quarterly unit walk around to assist the implementation of maintanence schedule for Grangemore. St Aidans due for closure Q4 2019 Post-Holder(s) responsible: CNM/ADoN/QPSC	Walkarounds will be recorded in the ward diary Oversight by the QPSC	Achievable	Ongoing
9. A programme of routine renewal of the fabric, and decoration of the premises was not developed, implemented, or documented, 22, 1 (c).	*Reoccurring*	Corrective Action(s): The Senior Managment Team have agreed that funding will be provided for all necessary repair work to address structural deficits in St. Aidans and Grangemore. This funding will be accessed by the CNMs subsequent to the provision of a quarterly report to the Service Manager. Post-Holder(s) responsible: Service Manager/CNM/ADoN/QPSC	Oversight by the QPSC	Achievable	Ongoing
		Preventative Action(s): The CNMs on St. Aidans and Grangemore units will carry out a quarterly unit walk around and submit a formal report to the Service Manager	Walkarounds will be recorded in the ward diary Oversight by the QPSC		

		outlining what accommodation deficits need to be addressed. St Aidans Unit due for closure Q4 2019 Post-Holder(s) responsible: CNM/ADoN/QPSC			
10. There was an inadequate number of toilets for the male residents in St. Aidan's ward, 22 (3).	New	Corrective Action(s): At the time of the inspection visit there were two male toilets in St. Aidans unit to address the toileting needs of five residents. Regrettably, the physical structure of the unit does not enable the service to provide the residents with additional toilet facilities. Alternative options to address this deficit have been considered but the Senior Management Team are unable to identify a realistic corrective action in this regards. Move to new premises in Quarter 4 2019 will ensure adequate toilet facilities for all residents. Post-Holder(s) responsible: CNM		Due to the difficulties in being able to provide the residents with additional toilet facilities, the service is not in a position to correct this until the closure of St Aidans Unit in Q 4 2019	Q4 2019
		Preventative Action(s): In Q4 2019 the residents of St. Aidans ward will transfer to a purpose built unit which has single en-suite toilet facilities. Post-Holder(s) responsible:Service Manager/QPSC	Oversight of new build by QPSC	Achievable	Q4 2019

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Report reference: Pages 40 & 41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
11. Four out of ten MPARs did not detail a record of all medications administered to the resident.	New	Corrective Action(s): A Memo was sent by the Assistant Director of Nursing and posted in the nursing office to remind staff of the requirement to record all medications administered to the resident in the MPARS and the requirement to record omission codes where medications have not been administered. Post-Holder(s) responsible:CNM/ADoN	Monthly Nursing Metrics	Achievable	Completed. Memo issued on 18th January 2019
		Preventative Action(s): Education and feedback of Medication Metric results on a monthly basis. Post-Holder(s) responsible:CNM/ADoN	Monthly Nursing Metrics	Achievable	Ongoing
12. Two out of ten MPARs did not have micrograms written in full.	New	Corrective Action(s): Memo issued to all medical staff by Consultant Psychaitrist to remind them of the requirements of writing micrograms in full Post-Holder(s) responsible: Consultant Psychiatrist.	Monthly Nursing Metrics	Achievable	Completed. Memo issued on 18th January 2019.
		Preventative Action(s): This requirement will be included in induction of NCHDS six montly. In future, any deficits identified by the monthly nursing metrics schedule with regard to this regulation will be notified to	Ongoing monitoring by the monthly Nursing Metrics. Governance through the Quality Patient Safety Committee	Achievable	Ongoing

		QPS committee leading to the implementation of an appropriate corrective action plan. Post-Holder(s) responsible:Clinical Tutor/Service Manager/ADoN/QPSC			

Regulation 26: Staffing

Report reference: Pages 44 - 46

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
13. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, and the management of violence and aggression, 26(4).	*Reoccurring*	Corrective Action(s):A schedule of trainingfor BLS, Fire Safety and the management of violence and aggression is in place. However, recruitment and retention staffing difficulties have an ongoing significant impact on the service's capacity to deliver up to date mandatory training to all staff. In view of this the Senior Management Team have given consideration to suspending clinical services in order to optimise compliance with this mandatory training requirement. This option will have to be considered and ratified by QSEC (Quality Safety and Executive Committee.) Post-Holder(s) responsible:Area DON/Service Manager/Heads of Discipline	Each Head of Discipline to monitor and maintain a record of signatures in unit policy folder	Achievable	Ongoing Presently
		Preventative Action(s): QPSC will oversee the issuance of a memo from all Heads of Discipline to inform staff of their requirement to maintain their mandatory training. Schedule of Fire Training increased to twice yearly (March and October 2019) Post-Holder(s) responsible: Service Manager	Each Head of Discipline to monitor and maintain a record of signatures in unit policy folder	Achievable	Ongoing

14. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccurring*	Corrective Action(s): QPSC will oversee the issuance of a memo from all Heads of Discipline to inform staff of their requirement to maintain their mandatorytraining. However, recruitment and retention staffing difficulties have an ongoing significant impact on the service's capacity to deliver up to date mandatory training to all staff. In view of this the Senior Management Team have given consideration to suspending clinical services in order to optimise compliance with this mandatory training requirement. This option will have to be considered and ratified by QSEC (Quality Safety and Executive Committee.) Post-Holder(s) responsible: Heads of Discipline	Each Head of Discipline to monitor and maintain a record of signatures in unit policy folder	Achievable	Ongoing
		Preventative Action(s): Review and oversight of training schedules by QPSC Post-Holder(s) responsible:QPSC/Heads of Discipline	Each Head of Discipline to monitor and maintain a record of signatures in unit policy folder	Achievable	Ongoing
15. The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, and the size and layout of the approved centre, 26 (2).	*Reoccurring*	Corrective Action(s): WWMHS has conducted a local bespoke and an overseas recruitment campaign to address nursing shortages. Unfortunately, these interventions have produced minimal results.	Review of daily rosters by allocations and ADoN	Ongoing national challenges in relation to recruitment and retention of nursing staff restrict the achievability of this CAPA.	Ongoing

		Post-Holder(s) responsible: : Area DON/Service Manager			
		Preventative Action(s):): WWMHS continue to actively address recruitment and retention difficulties within the service and are involved in negotiations with regard to skill mix. Post-Holder(s) responsible: Area DON/Service Manager			

Regulation 28: Register of Residents

Report reference: Page 48

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
16. The register was not up-to-date.	*Reoccurring*	Corrective Action(s):All omissions identified are now recorded in the register of residents Post-Holder(s) responsible:Mental Health Act Administrator	Review of register of residents.	Achievable	Completed
		Preventative Action(s): A new register of residents has been developed and trialed on another site to ensure it meets requirements of Regulation 28. Once the trial period has completed in Feb 2019, this new Register of Residents Database will be utilised for Grangemore and St. Aidan's. Post-Holder(s) responsible:Mental Health Act Administrator/QPSC	Over sight by the Mental Health Act Administrator and QPSC	Achievable	End Q 1 2019
17. The register did not include all of the information specified in Schedule 1 to these Regulations: • Diagnosis on admission not consistently recorded.	*Reoccurring*	Corrective and Preventative Action(s): A new register of residents has been developed and trialed on another site to ensure it meets requirements of Regulation 28 including diagnosis on admission, diagnosis on discharge, discharge date and resident status.	Over sight by the Mental Health Act Administrator and QPSC	Achievable	End Q 1 2019

• Diagnosis on discharge was not consistently recorded. • Discharge date was not consistently recorded. • Resident status, i.e. voluntary or involuntary, was not consistently recorded		Once the trial period has completed in Feb 2019, this new Register of Residents Database will be utilised for Grangemore and St. Aidan's. Post-Holder(s) responsible:Mental Health Act Administrator/QPSC			

Regulation 31: Complaints Procedures

Report reference: Pages 51 & 52

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
18. The Approved Centre did not ensure that all complaints and the results of any investigations, and any actions taken on foot of a complaint were fully and properly recorded, 31 (7).	New	Corrective Action(s): The CNM of each unit will maintain a record of all complaints within Grangemore and St. Aidan's and will manage these in a timely manner. All subsequent actions taken will be recorded. Post-Holder(s) responsible:Service Manager/CNM/QPSC	A log of all complaints will be maintained within the approved centre with ongoing monitoring and oversight by the QPSC	Achievable	Completed
		Preventative Action(s): The CNM of each unit will ensure that all complaints are managed promptly and records of actions and resolutions are maintained on the unit. Post-Holder(s) responsible: Service Manager/CNM/QPSC	A log of all complaints will be maintained within the approved centre with ongoing monitoring and oversight by the QPSC	Achievable	Completed Monitoring is ongoing

Use of Physical Restraint

Report reference: Pages 62 & 63

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
19. The Approved Centre did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy, 9.2 (b).	New	Corrective Action(s):A memo was sent by the Assistant Director of Nursing to all staff involved in physical restraint on January 18th 2019 to remind them of the requirement to read and sign the policy Post-Holder(s) responsible:ADoN	A record of signatures maintained in Unit Policy Folder	Achievable	Completed. Memo issued 18th January 2019
		Preventative Action(s): The CNM will monitor and notify all current and future nursing staff of the requirement for them to sign that they have read and understood the policy for the use of physical restraint at their monthly unit meeting Post-Holder(s) responsible:CNM	A record of signatures maintained in Unit Policy Folder	Achievable	Ongoing
20. A record of attendance at training was not maintained. 10.2.	New	Corrective Action(s): A training database has been in place since 2016 which is available to all CNM's online on a shared folder on the P-drive. A hard copy of record of attendance held in a folder on all units since 2016. Since the inspection visit the ADON has been instructed by the Area Director of Nursing to update the database and attendance record on a quarterly basis in order to address this area of non-compliance. Post-Holder(s) responsible: ADoN	Oversight of training needs by QPSC	Achievable	Completed

		Preventative Action(s): Ongoing monitoring of the training database by the ADoN Post-Holder(s) responsible:ADoN	Oversight of training needs by QPSC	Achievable	Ongoing
21. In two of the three episodes of physical restraint a same sex staff member was not present during the physical restraint episode, instead two members of the opposite sex to the resident was present during these two physical restraint episodes. 6.3.	New	Corrective Action(s): In accordance with the Code of Practice Section 6.3, 'where practicable' a same sex member of staff is present during an espisode of physical restraint. Post-Holder(s) responsible: CNM	Review of individual physical restraint episodes by the MDT	Not achievable Unfortunately due to recruitment and retention difficulties within the nursing service we regret that we are unable to ensure that a same sex staff member will be present during all future physical restraing episodes.	Ongoing
		Preventative Action(s): In accordance with the Code of Practice Section 6.3, where practicable a same sex member of staff is present during an espisode of physical restraint Post-Holder(s) responsible CNM:	Review of individual physical restraint episodes by the MDT	As above	Completed

Admission, Transfer and Discharge

Report reference: Pages 64 & 65

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
22. Not all relevant staff had signed to indicate that they had read and understood the admission and discharge policies, 9.1.	*Reoccurring*	Corrective Action(s): A memo will be sent by Heads of Disciplines to staff within their department to remind them of the requirement to read and sign the admission and discharge policies. A written record indicating that all relevant staff have read and understood the admission and discharge policy is maintained. Post-Holder(s) responsible: ADON/ Heads of Discipline	Record of signatures maintained in Unit Policy Folder	Achievable	End of Q.1 2019.
		Preventative Action(s): QPSC will oversee the issuance of a memo from all Heads of Discipline to remind staff to sign off on relevant policies as they are reviewed. Post-Holder(s) responsible: Head of Service who chairs the QPSC	Each Head of Discipline to monitor and maintain a record of signatures in unit policy folder	Achievable	Ongoing
23. Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies, 4.19.	New	Corrective Action and Preventative (s): QPSC willdevelop a schedule of auditing which will be inclusive of the admission, transfer and discharge policy 4.19. Post-Holder(s) responsible:Service Manager	Annual Audit	Achievable	End of Q2 2019
		Preventative Action(s): As above Post-Holder(s) responsible: Head of Service who chairs the QPSC	Annual Audit	Achievable	End of Q2 2019