Department of Psychiatry, University Hospital Waterford

ID Number: AC0034

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, University Hospital Waterford
Dunmore Road
Waterford

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Care for People with Intellectual Disability

Registered Proprietor:
HSE

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor Nominee:
Mr. David Heffernan, Acting Head of Services, CHO 5 Mental Health Services

Inspection Team:
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Inspection Date:
15 – 18 April 2019

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
3 – 6 July 2018

Date of Publication:
Monday 14 October 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2019 COMPLIANCE RATINGS

REGULATIONS

Compliant: 10
Non-compliant: 1
Not applicable: 1

RULES AND PART 4 OF THE MENTAL HEALTH

Compliant: 1
Non-compliant: 2
Not applicable: 4

CODES OF PRACTICE

Compliant: 20
Non-compliant: 0
Not applicable: 0
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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 2017 – 2019
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Inspector of Mental Health Services

Dr Susan Finnerty

1.0 Inspector of Mental Health Services – Review of Findings

In Brief

The Department of Psychiatry was located on the lower ground floor of University Hospital Waterford. It contained 44 beds in two areas, an acute unit Brandon ward, with 14 beds, and a sub-acute unit, Comeragh ward, with 30 beds. Recently developed dining room and sitting room facilities in Brandon ward were now fully operational. Residents were admitted under eight adult teams, three psychiatry of later life teams, and two rehabilitation teams.

The approved centre continues to struggle to achieve compliance with regulations, rules and codes of practice. There was 64% compliance in 2017 and 68% compliance in 2018. Compliance has now decreased to a low level of 57% in 2019. Seven non-compliances were rated high risk in this inspection. Seven areas of non-compliance with Regulations, Rules and Codes of Practice in this inspection have remained non-compliant in 2017, 2018 and 2019.

One area of compliance with the Regulations had a quality rating of excellent on this inspection, similar to 2018.

Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: The approved centre shall undertake building works, essential maintenance and refurbishments of the 14-bed unit to ensure there are adequate and appropriate communal spaces for therapeutic services, recreational activities, dining, and to facilitate visitors. These works shall be completed by 31st December 2017. Any potential delays to the works must be reported to the Mental Health Commission.

Finding on this inspection: The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 2: To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 2. The approved centre did, however, remain non-compliant with Regulation 26 Staffing in the area of mandatory training.
Safety in the approved centre

- There was suitable and sufficient catering equipment in the approved centre and proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned.
- All residents’ records were secure, up to date and were in good order.
- The ordering, prescribing, storage and administration of medication was satisfactory.

However:

- For two of three episodes of physical restraint reviewed, there was no evidence of a physical examination being carried out on the resident no later than three hours after the start of the episode of physical restraint.
- Not all health care staff had up to date training in the following areas: fire safety, Basic Life Support, management of violence and aggression, Mental Health Act 2001, and Children First.
- Not all staff involved in Electro-Convulsive Therapy (ECT) had appropriate training in Basic Life Support techniques.
- There was a risk of infection due to the lack of cleanliness in the toilet areas.

Appropriate care and treatment of residents

- Each resident had an individual care plan, into which they had input and which was developed by a multi-disciplinary team (MDT). These were regularly reviewed.
- There was a daily programme of therapeutic activities for both units which included input over the week from all health and social care professional groups and nurses. It was coordinated by the occupational therapy department and external agencies provided some of the therapeutic programmes. Groups included a coping skills group, a discharge-planning group, recovery principles, Cognitive Behavioural Therapy (CBT), music and ceramic group.

However:

- Residents’ general health needs were not monitored and assessed as indicated by the residents’ specific needs. The charts of five residents who had been in the approved centre over six months were reviewed. Physical examinations were inadequate, and did not consistently include an assessment of residents’ Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, and dental health.
- Eight children had been admitted to the approved centre since the last inspection in July 2018. The CAMHS consultant had clinical responsibility for each child.
Staff training records provided indicated that not all staff involved in the care of children within the approved centre had documented confirmation of training in Children First.

Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre and child residents did not have access to age-appropriate advocacy services.

The admission of children policy did not address the procedures in relation to family liaison, parental consent, and confidentiality or the requirement for each child to be individually risk-assessed.

### Respect for residents’ privacy, dignity and autonomy

- The layout and furnishings of the approved centre were conducive to resident privacy and dignity. Toilets and showers had locks with an override function. All beds had screening curtains, ensuring that their privacy was not compromised. Rooms were not overlooked by public areas, and all bedroom windows were fitted with curtains. Noticeboards did not display resident names or other identifiable information.
- The approved centre was kept in a reasonable state of repair, both internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, the repair of assistive equipment, and records of such were maintained.
- Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. Residents in seclusion had access to adequate toilet and washing facilities.

However:

- Residents did not have access to a supply of appropriate emergency personal clothing. There was only old clothing which was stored in a disorganised manner and it was unclear what was available concerning clothing size and gender-specific clothing. No emergency underwear was available to residents.
- An accurate record was not maintained of each resident’s personal property and possessions. Cash balances did not always correspond with the balance recorded in available records.
- Provisions were not made for the safe-keeping of each resident’s personal property and possessions. Residents’ property was stored in property areas within the approved centre but was not labelled and the property owner was not identifiable.
- The approved centre did not ensure that two staff were in attendance at all times when searches were being conducted. On inspection, it was found that at least one staff member was not the same gender as one resident who had been searched. A written record of all environmental searches was not kept.
- The unit lacked suitable wheelchair accessible toilet facilities for visitor use.
- The approved centre was not clean, hygienic, and free from offensive odours:
  - Two toilets were malodorous.
  - Bins were overflowing in both the male and female communal toilets in Comeragh Unit.
  - Discarded cigarette butts were found in the sink of the ladies communal toilet.
  - Thick cobwebs were observed on the skylight in Brandon Unit.
Brown staining was observed in the assisted bathroom on Brandon Unit.

- In Comeragh Unit, the visiting room upholstery was significantly worn.
- CCTV monitors were not viewed solely by the health professional responsible for the health and safety of the resident. CCTV monitors in both nurses’ stations were viewable to the public from the corridors through glass panels and anyone passing the nurses’ office could see the monitor and CCTV images.
- It was not apparent that the patient was informed of the ending of seclusion in all cases. A documented record of follow-up review of the episode by members of the MDT was not available in all cases.

**Responsiveness to residents’ needs**

- Residents in the approved centre were provided with a variety of wholesome and nutritious food and menus were reviewed by the hospital dietitian. Residents had at least two choices for meals.
- Scheduled maintenance of the garden area of Brandon ward meant that, during the course of this inspection, residents on this unit had no access to an area suitable for outdoor recreation.
- Recreational activities in the approved centre were scheduled from Monday to Friday each week for each unit. Activities usually took place in the activity day centre and residents from Brandon Unit were brought over to attend, as appropriate. In Brandon Unit, group activities included orientation and news updates, a light exercise group, community meetings, mindfulness group, and arts and crafts group. A Move Your Mood group offered the opportunity for residents to undertake outdoor physical activity.
- Separate rooms were designated for visiting purposes in Comeragh Unit. The dining room in Brandon Unit was used to facilitate visits taking place.
- The resident information booklet detailed housekeeping arrangements and MDTs. The approved centre used the National Health Service (NHS – UK Health Service) to provide written information on diagnosis and medications.
- Complaints procedures and implementation was satisfactory.

**However:**

- While there was a suitable room for child visits, two residents reported that they repeatedly could not access this room with their children as the room was frequently used for MDT meetings.
- Information regarding national screening programmes was found to be unavailable to residents in the approved centre.

**Governance of the approved centre**
The Department of Psychiatry, University Hospital Waterford was part of the HSE South East Community Healthcare (SECH) area, previously known as Community Healthcare Organisation (CHO) Area 5. The centre provided in-patient beds for Waterford, part of south Kilkenny, and for most of county Wexford.

Governance structures included an area Executive Management Committee (EMT), an area Quality and Safety Executive Committee (QSEC), and a local Quality Patient Safety Committee (QPSC). Both clinical and management staff were involved in these governance groups.

Governance processes had identified a variety of risk issues relating to the approved centre. These related particularly to staffing, overcrowding, training deficits, and structural maintenance of the approved centre. Where appropriate, risks were incorporated in the risk register and reviewed on an on-going basis.

Service user input was facilitated by the participation of the Area Lead for Mental Health Engagement in management and governance processes.

Incidents were recorded and risk-rated in a standardised format, and all clinical incidents were reviewed by the MDT at their regular meeting.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. New televisions and entertainment devices for main sitting room and single rooms.


5. Updated physical health screening protocol introduced in February 2019.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located in a lower ground floor area at the rear of University Hospital Waterford (UHW). It contained a total of 44 beds, 14 in an acute unit, now named Brandon ward, and 30 beds in a sub-acute unit, now named Comeragh ward. Access to the unit was clearly signed from the main entrance area to the hospital.

Recently developed dining room and sitting room facilities in Brandon ward were now fully operational and this provided much needed facilities for residents in this area. A neighbouring building project had been completed and this had improved the overall environment of the approved centre.

Accommodation with the approved centre was a mixture of single and two, four, and six-bedded shared bedrooms. Residents were admitted by eight adult teams, three old-age teams, and two rehabilitation teams.

Scheduled maintenance to the garden area of Brandon ward meant that during the course of this inspection residents on this unit had no access to an area suitable for outdoor recreation. This matter had been in place for some weeks and it was hoped that it would be resolved in the coming 1-2 weeks.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>44</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>43</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Number of wards of court</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Number of patients on Section 26 leave for more than 2 weeks</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The Department of Psychiatry (DOP) was part of the HSE South East Community Healthcare (SECH) area, previously known as Community Healthcare Organisation (CHO) Area 5. The centre provided in-patient beds for Waterford, part of south Kilkenny, and for most of county Wexford.

Governance structures included an area Executive Management Committee (EMT), an area Quality and Safety Executive Committee (QSEC), and a local Quality Patient Safety Committee (QPSC). Minutes of these various committees were provided to the inspection team. It was apparent that an active governance
process with focus at area and local level on issues of risk and quality service development was in place. Both clinical and management staff were involved in these governance groups.

Heads of discipline had regular direct engagement with the approved centre and with staff directly involved in the operation of the centre.

Governance processes had identified a variety of risk issues relating to the approved centre. These related particularly to staffing, overcrowding, training deficits, and structural maintenance of the approved centre. Where appropriate risks were incorporated in the risk register and reviewed on an on-going basis. Service user input was facilitated by the participation of the Area Lead for Mental Health Engagement in management and governance processes.

3.3 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.
4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 25: The Use of Closed Circuit Television</td>
<td>✓</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>✓</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Code of Practice relating to the Admission of Children under the Mental Health Act 2001</td>
<td>X</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>X</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td></td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.
4.2 Areas of compliance rated “excellent” on this inspection

The following area was rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td></td>
</tr>
</tbody>
</table>

4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As no resident had been mechanically restrained since the last inspection, this rule was not applicable.</td>
</tr>
</tbody>
</table>
5.0 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 Irish Advocacy Network (IAN) representative was contacted to obtain residents’ feedback about the approved centre.

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.

In total, six residents met privately with the inspectors. In addition, the inspectors met with the IAN representative who submitted a report on her engagement with residents. A number of residents returned service user experience questionnaires. While overall residents reported a positive experience, concerns were expressed regarding overcrowding on the unit, lack of adequate activities, particularly at weekends, and lack of adequate access to the outdoors. A number of residents expressed concern at the overall hygiene within the unit, and also at the lack of current access to the outdoors from Brandon ward.
6.0 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:

- General Manager – Registered Proprietor
- Head of Service
- Executive Clinical Director
- Principal Psychologist
- Senior Occupational Therapist (for Occupational Therapy Manager)
- Service Manager
- Area Director of Nursing
- Assistant Director of Nursing (ADON) x 2
- ADON/Risk Manager
- Clinical Nurse Manager 2 x 2

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The service advised that they were seeking to obtain dietetic services and that the risk had been identified. They undertook to ensure that staff were familiarised with the applicable nutritional tool and that it was brought into general use. The service also outlined that they had sought to prioritise training but accepted that work needed to be done in this area to ensure that the requirements of the condition applying were met. The service undertook to forward evidence of staff training in food safety processes to the lead inspector for consideration.
7.0 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
The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

**Regulation 4: Identification of Residents**

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*.

**Processes:** 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 identifying residents, as set out in the policy.

**Training and Education:** 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.

**Monitoring:** The approved centre used a sticker system to identify residents. The sticker included the resident’s name, address, and date of birth. Identifiers used were person specific, and did not include a room number or physical location. Two appropriate resident identifiers were used when administering medication, medical investigations, and providing other healthcare services. Appropriate resident identifiers were used prior to the provision of therapeutic services and programmes. The approved centre used alert stickers to assist staff in distinguishing between residents with the same or similar names.

**Evidence of Implementation:** 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

(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: 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: Residents in the approved centre were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Food for the approved centre came from University Hospital Waterford, and menus were reviewed by the hospital dietitian. Residents had at least two choices for meals, and hot meals were provided on a daily basis. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

For residents with special dietary requirements, an evidence-based nutrition assessment tool was not used. The approved centre did not have access to a dietitian. The nutritional needs of residents were not adequately identified, and were not regularly reviewed, as access to a dietitian was no longer available.

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 evidence of implementation pillar.
**Regulation 6: Food Safety**

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to food safety, which was approved in March 2019. The policy addressed requirements of the Judgement Support Framework, with the exception of the management of catering and food safety equipment.

**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 safety, as set out in the policy. Not all staff handling food had up-to-date training in food safety commensurate with their role.

**Monitoring:** Food safety audits had not 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, and there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. 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, training and education, monitoring pillars.
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre 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. Relevant staff interviewed were able to articulate the processes for residents’ clothing, as set out in the policy.

Monitoring: No residents were prescribed night clothing during daytime hours. The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis.

Evidence of Implementation: Residents were facilitated to do their laundry on Comeragh Unit. There was a washing machine and dryer in the laundry room in the activities area of the unit. Residents were also encouraged to send laundry home for family members to undertake. Where residents were unable to do either of the above, nurses undertook the residents’ laundry on the unit or sent it in labelled bags to the main hospital laundry.

When required, residents did not have access to a supply of emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. There was only a store of old clothing kept in the laundry room of Comeragh Unit and linen room. Clothing was stored in a disorganised manner and it was unclear what was available concerning clothing size and gender-specific clothing. No emergency underwear was available to residents. The approved centre had access to hospital pyjamas.

The approved centre was non-compliant with this regulation because residents in the approved centre were not provided with adequate emergency clothing, with due regard to his or her dignity and bodily integrity at all times, 7 (1).
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in July 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. Not all relevant staff interviewed were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were not 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: Each resident had their own wardrobe, which was locked on request to nursing staff. Residents were not provided with a key as all wardrobes were opened by the same key. Any overflow of residents’ possessions was stored in rooms which were not dedicated property rooms.

On Comeragh Unit, property was stored in the Electro Convulsive Therapy (ECT) recovery room. There were many bags of clothing in the room, some without labels. The staff nurse present did not know who owned the unlabelled bags of clothing or whether owners were presently admitted or discharged from the unit. On Brandon Unit, property was stored in the assisted bathroom. Again, many of the bags were unlabelled and the staff nurse was unsure who owned what items, or whether they were still admitted to the unit.

Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. Key pad safes were installed in each resident’s wardrobe, and residents could place all money and valuables inside the safe. This could be accessed with a generic code by nurses. Residents could set their own personal code if they chose to. Residents were entitled to bring personal possessions with themselves, the extent of which was agreed upon at admission. The access and use of...
resident monies was not always overseen by two members of staff. On inspection, two staff nurses reported that records of cash balance were not maintained. Nursing staff opened and closed a residents’ safe when requested by residents. Signatures were not requested on Brandon Unit. It was also noted that the safe of one resident contained a wallet, with no accompanying record concerning the sum of money inside it.

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

a) The registered proprietor did not ensure that an accurate record was maintained of each resident’s personal property and possessions. Cash balances did not always correspond with the balance recorded in available records, 8 (3).

b) Provisions were not made for the safe-keeping of each resident’s personal property and possessions. Residents’ property was stored in property areas within the approved centre but was not labelled and the property owner was not identifiable, 8 (6).
**Regulation 9: Recreational Activities**

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

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**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 addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The process for developing recreational activity programmes.
- The facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to 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 for recreational activities, as set out in the policy.

**Monitoring:** A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake and attendance. Documented analysis had 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. Recreational activities in the approved centre were scheduled from Monday to Friday each week for each unit. Activities usually took place in the activity day centre and residents from Brandon Unit were brought over to attend, as appropriate. In Brandon Unit, group activities included orientation and news updates, a light exercise group, community meetings, mindfulness group, and arts and crafts group.

On weekends, the activity centre on Comeragh Unit was closed. However, residents had access to TV, books, cards and board games in the sitting room area. On Brandon Unit, an activity box of items was left in the unit for residents to access, and TV and board games were also available. Nursing staff could retrieve items from the activity centre as requested by residents. A *Move Your Mood* group offered the opportunity for residents to undertake outdoor physical activity. Choice of activity was decided by residents at community meetings, such as bowling and walking.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in May 2016. 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. 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 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. Facilities were provided within the approved centre for residents’ religious practices, as appropriate. There was an oratory in the main hospital and church on the grounds of the main hospital. In addition, multi-faith ministers were available via the main hospital. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. 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 monitoring pillar.
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in September 2016. The policy addressed requirements 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: Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Excluding meal times, visiting times were appropriate and reasonable. Separate rooms were designated for visiting purposes in Comeragh Unit. The dining room in Brandon Unit was used to facilitate visits taking place. The room in Comeragh Unit was slightly cluttered and had older style furnishings. Children visiting were accompanied at all times to ensure their health and safety. This was adequately communicated to all relevant individuals publicly.

While there was a suitable room for child visits, two residents reported that they repeatedly could not access this room with their children as the room was frequently used for multi-disciplinary team meetings. Both of these residents stated that staff would subsequently direct the child visits off the ward.

The approved centre was non-compliant with this regulation because the designated visitors room was not always available for children visiting, which meant there were not always appropriate arrangements and facilities in place for children visiting a resident, 11 (5).
Regulation 12: Communication

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication, which was last reviewed in January 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. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Wi-Fi internet connection was available for residents in University Hospital Waterford. Residents had access to mail, fax, e-mail, and telephone. At the time of inspection, no resident had associated risk documented with respect to external communications. The clinical director, or senior staff member designated by the clinical director, only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may have resulted in harm to the resident or to others.

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 13: Searches

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

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

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

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

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy in relation to the implementation of resident searches, which was last reviewed in May 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she 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.

**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 searching processes, as set out in the policy.

**Monitoring:** A log of searches was maintained. Each search record had not been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had not been completed to identify ways of improving search processes.

**Evidence of Implementation:** Resident consent was sought prior to all personal searches, and the request for consent, as well as the received consent were documented for every search of a resident and every property search. Where consent was not conveyed by a resident, this was documented and the subsequent process relating to searches without consent was implemented. The resident search policy and procedure were communicated to all residents at admission. Residents were informed by those implementing the search of what was happening during the search and why. Policy requirements were
implemented when illicit substances were found as a result of a search. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

General written consent, however, was not sought for routine environmental searches. The clinical file of one resident who was searched was inspected in relation to search processes. The approved centre did not ensure that two staff were in attendance at all times when the search was being conducted. The search was not implemented with due regard to the resident’s dignity, privacy, and gender. On inspection, it was found that at least one staff member was not the same gender as the resident being searched. A written record of all environmental searches was not kept.

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

- a) Not all searches were undertaken with due regard to the resident’s dignity, privacy, and gender. At least one staff member was not the same gender as the resident being searched, 13 (7).
- b) The written record of the search inspected did not document the reasons for, and who participated in, the search, 13 (8).
Regulation 14: Care of the Dying

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.
(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.
(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.
(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.
(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

Processes: The approved centre had a written 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: Relevant staff had not 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.

The monitoring and evidence of implementation pillars were not applicable, as no deaths had occurred in the approved centre since the last inspection.

The approved centre was compliant with this regulation.
**Regulation 15: Individual Care Plan**

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre 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. Not 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:** Ten ICPs were inspected. All ICPs reviewed were developed by the MDT following a comprehensive assessment, within seven days of admission. Residents were given an MDT care plan evaluation form to complete before the review meeting. The care plan was reviewed and updated at each meeting and rewritten each time. In this regard, residents’ families were involved in the process, as appropriate.

ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. ICPs identified the resources required to provide the care and treatment identified. Where applicable a family member attended the ICP meeting, and ICPs were reviewed by the MDT in consultation with the resident, weekly at a minimum.

In two of the ten ICPs inspected, it was not indicated if the resident had been offered a copy. In two ICPs inspected there was no record to indicate whether the resident had declined or taken a copy of the ICP.

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 evidence of implementation pillars.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in June 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: 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: A programme of therapeutic activities for both units daily included input over the week from all allied health professional groups and nurses. Coordinated by the occupational therapy department and facilitated by another allied health professional, there was a balanced mix of specific therapeutic groups such as mindful discussion group (facilitated by Shine), and Waterford Healing Art Therapy (WHAT), both of whom were external agencies providing some of the therapeutic programmes. These were co-facilitated by staff from the Occupational Therapy department.

Other groups provided for the therapeutic programme were delivered and facilitated weekly by the occupational therapy department and co-facilitated by psychology or social work. This included a coping skills group, a discharge-planning group, and a recovery principles, music and ceramic group. From time to time, there was a baking group. A recent addition to the programme was a Cognitive Behavioural Therapy (CBT) group. A social worker was on site weekly to assess and manage these requirements as was appropriate and practicable. Longer term work was referred to the respective social worker on the resident’s team.

Therapeutic services and programmes provided by the approved centre were evidence-based, and directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Where a required therapeutic service or programme was not provided internally, the approved centre arranged for the provision of the service by a qualified health professional in an appropriate location.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy 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: 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.

No residents had been transferred since the last inspection, so the monitoring and evidence of implementation pillars were not inspected against.

The approved centre was compliant with this regulation.
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The general health policy was last reviewed in May 2018. The policies and procedures addressed requirements of the Judgement Support Framework, with the exception of the management, response, and documentation of a medical emergency, including cardiac arrest.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. 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 policies.

Monitoring: A systematic review had not 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: The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with individual care plans (ICPs). Residents’ general health needs were not monitored and assessed as indicated by the residents’ specific needs. Six residents had been in the approved centre over six months, one of whom was on extended leave. The charts of five residents were reviewed. Physical examinations were inadequate, and did not consistently include an assessment of residents’ Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, and dental health.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing, such as lab results. Information regarding national screening programmes was found to be unavailable to residents in the approved centre.

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

a) One resident did not receive a six-month general health check within the required time frame,

19 (1)(b).
b) Not all six monthly general health checks were completed in full. Physical examinations were inadequate, and did not consistently include an assessment of residents’ Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, and dental health, 19 (1)(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of information to 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 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 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: The resident information booklet detailed housekeeping arrangements, including arrangements for personal property and mealtimes, visiting times and arrangements, and details of relevant advocacy and voluntary agencies. Residents were provided with the details of their multi-disciplinary team. The approved centre used the National Health Service (NHS – UK Health Service) service, which was a user-friendly website. This website provided written information on diagnosis. This was unless, in the treating psychiatrist’s view, provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. Justification for restricting information regarding a resident’s diagnosis was documented in their clinical file.

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 in the approved centre had access to interpretation and translation services 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 training and education and monitoring pillars.
### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2018. 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 addressed by their preferred names, and staff members interacted with residents in a respectful manner. Staff were discreet when discussing residents’ condition or treatment needs. Residents wore clothing that respected their privacy and dignity. Both units of the approved centre had portable phones that residents could use in private areas. Noticeboards did not display resident names or other identifiable information.

The layout and furnishings of the approved centre was conducive to resident privacy and dignity. Toilets and showers had locks with an override function. All beds had screening curtains, ensuring that their privacy was not compromised. Rooms were not overlooked by public areas, and all bedroom windows were fitted with curtains. The main resident garden area was overlooked by other hospital facilities.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the residents’ privacy and dignity was appropriately respected at all times; Comeragh Unit garden was overlooked by a public area.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in July 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. 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 a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and appropriately sized communal rooms were provided. Heating in bedrooms and day areas was suitable and sufficient. Rooms were ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. Lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs. Where water was leaking through the ceiling, yellow hazard signs were placed on the floor, and regular drying of water was also undertaken. A ligature audit had been completed in March 2019. This confirmed that ligature points had been minimised to the lowest practicable level, based on risk assessment.

There was a sufficient number of toilets and showers for residents in the approved centre. On Comeragh Unit, two of four single bedrooms were en suite, with four communal toilets and two shower rooms available on the unit. All shared rooms had toilets. All resident bedrooms were appropriately sized to address the residents’ needs. The unit lacked suitable wheelchair accessible toilet facilities for visitor use.
The approved centre did not provide suitable furnishings to support resident independence and comfort. In Comeragh Unit, the visiting room upholstery was significantly worn.

The approved centre was kept in a reasonable state of repair, both internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, the repair of assistive equipment, and records of such were maintained.

The approved centre was not clean, hygienic, and free from offensive odours: two toilets were malodourous, and bins were overflowing in both the male and female communal toilets in Comeragh Unit. Discarded cigarette butts were found in the sink of the ladies communal toilet. In addition, thick cobwebs were observed on the skylight in Brandon Unit, and brown staining was observed in the assisted Bathroom on Brandon Unit. Several generators on-site were tested on a weekly basis, ensuring that back-up power was available in the approved centre. Due to external work being undertaken in the garden area of Brandon Unit, residents did not have access to a suitable outdoor area.

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

a) The approved centre was not adequately clean. Bins were overflowing in both the male and female toilets in Comeragh Unit. There were discarded cigarette butts in the sink of the ladies communal toilet in Comeragh Unit. The bath within the assisted bathroom on Brandon Unit was dirty. Thick cobwebs were observed on the ceiling in Brandon Unit, 22, 1(a).

b) The approved centre environment was not developed with due regard to the specific needs and well-being of residents. Residents had no access to outdoor space on Brandon Unit, 22 (3).

c) The premises was not maintained in good decorative condition; furniture upholstery within Comeragh Unit visiting room was significantly worn and damaged, 22 (1)(a).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in March 2019. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff, as well as 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. All nursing and medical staff, as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: The MPARs of ten residents were inspected. All entries in the MPARs were legible and written in black, indelible ink. 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, and this was documented in the clinical file. Prescriptions were not altered where a change was required. Instead, the medical practitioner rewrote the prescription, as required.

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 in the approved centre was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Medication storage areas were free from damp, mould, clean, free from litter, dust and pests and free from spillage or breakage. Food and drink were not stored in areas used for the storage of medication. Dispensed medication was kept in locked trolleys, which were stored in a secure internal pharmacy. The medication trolley remained locked at all times, and was secured in a locked room. Scheduled 2 and 3 controlled drugs locked in separate cupboard from other medicinal products in order to ensure further security.

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 24: Health and Safety

(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 in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in March 2019. The written policy in relation to health and safety of residents, staff, and visitors, and the associated safety statement were dated March 2019.

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 policy.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2019. The policy addressed all of the Judgement Support Framework, with the exception of the measures used to ensure the privacy and dignity of residents where the approved centre used CCTV cameras or other monitoring equipment.

Training and Education: All relevant 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 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: Clear signs were located throughout the approved centre in prominent positions where CCTV cameras or other monitoring systems were located. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The use of CCTV and other monitoring systems had been disclosed to the Mental Health Commission and Inspector of Mental Health Services. CCTV cameras and other monitoring systems used to observe a resident were incapable of recording or storing a resident’s image. CCTV cameras and other monitoring systems were not viewed solely by the health professional responsible for the health and safety of the resident. CCTV monitors in both nurses’ stations were viewable to the public from the corridors through glass panels. Anyone passing the nurses’ office could potentially see the monitor and CCTV images.

The approved centre was non-compliant with this regulation because the CCTV monitor located in the nurses’ office was not viewed only by the health professional responsible for the health and welfare of
the resident. It was visible to the public and anyone passing the nurses’ office could potentially see the monitor and CCTV images, 25 (1).
Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in March 2019. The policy did not address the following:

- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The roles and responsibilities in relation to staff training processes within 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 staffing, as set out in the policy.

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. 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: Staff were recruited and selected in accordance with the approved centres policy and procedures which were reflective of national recruitment and appointment processes. The number and skill mix of staffing was adequate to meet resident needs. An organisational chart outlining the management structure and lines of accountability was documented within the centre’s Safety Statement.

Staff had the appropriate qualifications and skills to discharge the roles allocated. A staff rota was maintained within the approved centre and was available to staff. A copy was provided to the inspectors. An appropriately qualified member of staff was in charge at all times. Staff were provided with the opportunity for further education and these opportunities were communicated to staff.

The approved centre did not have a written staffing plan. Staff in the approved centre had access to the Mental Health Act (2001) and the associated documents dealing with the Regulations, Rules, and Codes.

Not all health care staff had up to date training in the following areas:
- fire safety
- Basic Life Support
- Management of violence and aggression (PMAV)
- Mental Health Act 2001
- Children First

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (44)</td>
<td>19</td>
<td>47%</td>
<td>35</td>
<td>90%</td>
<td>44</td>
</tr>
<tr>
<td>Consultant Psychiatrist (15)</td>
<td>9</td>
<td>60%</td>
<td>12</td>
<td>80%</td>
<td>9</td>
</tr>
<tr>
<td>Medical (18)</td>
<td>16</td>
<td>88%</td>
<td>15</td>
<td>83%</td>
<td>15</td>
</tr>
<tr>
<td>Occupational Therapist (10)</td>
<td>10</td>
<td>100%</td>
<td>10</td>
<td>100%</td>
<td>10</td>
</tr>
<tr>
<td>Social Worker (6)</td>
<td>1</td>
<td>16%</td>
<td>5</td>
<td>83%</td>
<td>3</td>
</tr>
<tr>
<td>Psychologist (8)</td>
<td>7</td>
<td>87%</td>
<td>7</td>
<td>87%</td>
<td>7</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brandon &amp; Comeragh</td>
<td>CNM3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>3 WTE</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.2 WTE</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0.5 WTE</td>
<td>-</td>
</tr>
</tbody>
</table>

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN)*

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

a) Not all staff had up-to-date training in Basic Life Support, fire safety, management of violence and aggression and Children First, 26(4).

b) Not all the staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in May 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

Training and Education: Not all clinical staff and other relevant staff had signed the signature log 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 had been trained in best-practice record keeping.

Monitoring: Resident records were not 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: All residents’ records were secure, up to date, in good order and were constructed, maintained and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents’ current status and the care and treatment being provided. Resident records were developed and maintained to a logical sequence. Resident records were maintained appropriately, including records being written legibly in black indelible ink, being photocopied and readable, and entries were factual consistent, 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 of food safety, health and safety, and fire inspections was maintained in the approved centre.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
Regulation 28: Register of Residents

(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

A documented electronic register of all residents admitted to the approved centre was available. This register contained the following information: full name; address; gender; date of birth; country of birth; next of kin or representative(s); admission date; and discharge date, as applicable. The electronic register of residents was up-to-date, and was made available to the Mental Health Commission, where requested.

Diagnosis on admission, or provisional diagnosis where one was not available, as well as the status of the resident (voluntary or involuntary) was not documented on the register. In addition, discharge diagnosis was not consistently documented.

The approved centre was non-compliant with this regulation because the register did not contain all of the information specified under Schedule 1, 28 (2), due to the following:

a) Diagnosis on admission or provisional diagnosis was not documented.

b) Resident status (voluntary or involuntary) was not documented on the register.

c) Discharge diagnosis was not consistently documented.
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy 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 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 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. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

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

(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 had a private tribunal room to ensure the appropriate facilities were available for Mental Health Tribunals. Adequate resources were provided to support the Mental Health Tribunal process, as required. Additionally, staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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

(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 in relation to the management of complaints. The policy was last reviewed in May 2018. The policy 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 completed. Complaints data was not analysed.

Evidence of Implementation: There was a nominated complaints officer responsible for dealing with all complaints who was available to the approved centre. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan. Time frames for complaints in the approved centre were in accordance with the Your Service, Your Say initiative.

Where required, the complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them, and this was documented. As required, the complainant’s satisfaction, or dissatisfaction, with the investigation findings was documented. As specified in the policy, all information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003, and the Freedom of Information Act 1997 and 2003.

COMPLIANT

Quality Rating: Satisfactory
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
(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 responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Training and Education: All relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. 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 not 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 been completed to identify opportunities for improving risk management processes.
Evidence of Implementation: The staff responsible for risk were known in the approved centre. The risk management procedures implemented had reduced risk in the approved centre. Clinical risks were identified, assessed, treated, reported, monitored, and documented in the risk register, as appropriate. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation, and they were documented within the risk register, as appropriate. A process to minimise ligature risks was underway in the approved centre. Corporate risks were identified, assessed, treated, reported and monitored by the approved centre, and documented in the risk register. Building works were underway at the time of inspection, with processes in place to minimise risk to residents.

Individual risk assessments were completed prior to and during resident seclusion, physical restraint, and specialised treatment such as Electro-Convulsive Therapy (ECT). The risk manager in the approved centre outlined the requirements for the protection of children and vulnerable adults, which were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format, and all clinical incidents were reviewed by the multi-disciplinary team (MDT) at their regular meeting. A six-month summary report was available, indicating all incidents to the Mental Health Commission. Information provided was anonymous at resident level in this respect. An emergency plan that specified responses by the approved centre staff to possible emergencies was available. The evacuation procedures were documented within the emergency plan.

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
<table>
<thead>
<tr>
<th>Regulation 34: Certificate of Registration</th>
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</thead>
<tbody>
<tr>
<td><strong>COMPLIANT</strong></td>
</tr>
</tbody>
</table>

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 and included the conditions applying to the registration of the approved centre.

The approved centre was compliant with this regulation.
EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated June 2018. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. Not all staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: There was a dedicated ECT suite in a specified location in the critical care area. The ECT suite had a private waiting room, an adequately equipped treatment room, and an adequately equipped recovery room. The approved centre had a facility for monitoring EEG on two channels. ECT machines were regularly maintained and serviced, and a record of maintenance was kept. In addition, there was confirmation of servicing of ECT machines. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Also, new guidelines for anaesthesia had been updated in 2018. There was a named consultant psychiatrist (CP) with overall responsibility for ECT management, and a named consultant anaesthetist with overall responsibility for anaesthesia. There were two identified nurses in the ECT suite at all times, and a further ten in the approved centre who were adequately accredited. The clinical file of one patient who had received ECT since the last inspection was reviewed. Processes were documented satisfactorily.

The approved centre was non-compliant with this rule because not all staff involved in ECT had received appropriate training and education in Basic Life Support techniques, 10.7.
Section 69: The Use of Seclusion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated March 2019. The approved centre had separate written policies in relation to the use of seclusion, the training of staff in relation to the use of seclusion, and the use of CCTV for observing residents in seclusion.

The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

Training and Education: There was no written record to indicate that staff involved in seclusion had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. Residents in seclusion had access to adequate toilet and washing facilities. In addition, all furniture and fittings were designed and of a quality so as not to endanger patient safety. Seclusion rooms in the approved centre were not used as bedrooms.

The clinical files relating to three episodes of seclusion were reviewed. Seclusion was initiated by a registered medical practitioner (RMP) or by a registered nurse. The consultant psychiatrist (CP) was notified as soon as practicable of the use of seclusion. Seclusion was only used in rare and exceptional circumstances following consideration of less restrictive options. The resident was informed of the reason for, likely duration, and circumstances leading to the discontinuation of seclusion. A medical review of the patient was undertaken no later than four hours after the commencement of the episode of seclusion.
It was not apparent that the patient was informed of the ending of seclusion in all cases. A documented record of follow-up review of the episode by members of the multi-disciplinary team was not available in all cases.

The seclusion register was signed by the responsible Consultant Psychiatrist or by the duty Consultant Psychiatrist within the designated 24-hour timeframe.

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

a) There was no written record indicating that staff involved in the process of seclusion had read and understood the policy, 10.2 (b).

b) Documentary evidence that the patient was informed of the ending of seclusion was not available in all cases, 7.3.

c) It was not evident that all episodes of seclusion were reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days of the episode, 10.3.
9.0 Inspection Findings – Mental Health Act 2001

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined.

Following administration of medication for a continuous period of three months, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent. The relevant Form 17 Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed in all cases.

This included the name of medications prescribed, and confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications. This was also documented in the progress notes.

Details of the discussion included the following: the nature and purpose of the medication(s); the effects of the medication(s), including any risks and benefits; and views expressed by the patient; any supports
provided to the patient in relation to the discussion and their decision-making; approval by a consultant psychiatrist; and authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated May 2018. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: Three episodes of physical restraint were reviewed. In all cases, physical restraint was used in rare, exceptional circumstances and was in the best interests of the resident, or where the resident posed an immediate threat of serious harm to the self or others. Physical restraint was only used after all alternative interventions to manage resident’s unsafe behaviour had been considered. All cases of physical restraint were based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when physical restraint was used in all three cases inspected.

Physical restraint was initiated by a registered medical practitioner (RMP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on the use of physical restraint. Designated staff members responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident were evident. The consultant psychiatrist (CP) or the duty CP was notified as soon as practicable, and this was recorded in the clinical file. There was no documented evidence that a medical examination of a resident was completed in all cases within the appropriate three hour period after the initiation of the episode of physical restraint.

In the cases reviewed, the order of physical restraint lasted for a maximum of 30 minutes, and the episode was recorded in the clinical file. A clinical practice form (CPF) was completed by the person initiating and ordering the use of physical restraint no later than three hours after the initiation of the episode. This was signed by the CP within 24 hours. In two of three cases reviewed, there was no documentary evidence that the resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. Additionally, the reason for not informing the resident was not documented in the clinical file.

In one case, the resident’s next of kin or representative was not informed of the use of physical restraint, and a pertinent record of this communication was not placed in the clinical file. Additionally, the next of kin or representative was not informed of the justification for physical restraint, and this was not addressed in the clinical file. Staff were aware of relevant considerations in individual care plans pertaining...
to the resident’s requirements or needs in relation to the use of physical restraint, and this may include advance directives.

Residents were afforded the opportunity to discuss the episode with members of the MDT involved as soon as was practicable. The completed CPF was placed in the resident’s clinical file. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

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

a) For two of three episodes of physical restraint reviewed, there was no evidence in support of a physical examination being carried out on the resident no later than three hours after the start of the episode of physical restraint, 5.4.

b) There was no evidence that the resident had been informed of the reason for and likely duration of restraint in all cases, 5.8.

c) In one case reviewed, the resident’s next of kin was not informed or, if not done explanation as to why this was the case, 5.9.
Admission of Children

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of children, which was last reviewed in June 2015. The policy detailed the procedures for identifying the person responsible for notifying the Mental Health Commission regarding child admissions.

The policy did not address the procedures in relation to family liaison, parental consent, and confidentiality. The policy did not detail the requirement for each child to be individually risk-assessed.

Training and Education: Staff training records provided indicated that not all staff involved in the care of children within the approved centre had documented confirmation of training in Children First.

Evidence of Implementation: Eight children had been admitted to the approved centre since the last inspection. The clinical files inspected indicated that provisions were in place to ensure the safety of the children, and to respond to the child’s particular needs as a young person in an adult setting. There were no specific provisions in place to ensure the rights of the child to have their views heard.

Staff having contact with children had undergone Garda vetting, and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was available for children, including age and gender segregated sleeping and bathroom areas. Each child was accommodated in a single room with a dedicated staff member. Gender sensitivity was demonstrated in all cases. The children had their rights explained and were provided with information about the available facilities in a form and language that they could understand. The clinical files recorded each child’s understanding of the explanation given to them on their rights.

Advice from the Child and Adolescent Mental Health Service (CAMHS) was available in all eight cases. The CAMHS consultant had clinical responsibility for each child. Consent for treatment was obtained from one or both parents. The Mental Health Commission was notified of the child admissions within the required 72-hour time frame.

Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre and child residents did not have access to age-appropriate advocacy services.

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

a) The policy did not detail the requirement for each child to be individually risk-assessed, 2.5 (i).

b) The policy did not address the procedures in relation to family liaison, parental consent, and confidentiality, 2.5 (l).

c) There were no specific provisions in place to ensure the rights of the child to have their views heard, 2.5 (c)(iii).

d) Child residents did not have access to age-appropriate advocacy services, 2.5 (g).
e) Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre, 2.5 (b).
f) Not all staff had received appropriate training relating to the care of children, 2.5 (e).
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated June 2018. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. Not all staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The dedicated ECT suite in the approved centre was located in Comeragh Unit, with a waiting room and a recovery room. The waiting room was private, the ECT suite was adequately equipped, and there was an adequately equipped recovery room. The waiting room was used for outpatients only.

The clinical file of one resident who had received ECT was reviewed. Procedures relating to consent and the provision of ECT were thoroughly documented.

The approved centre had a facility for monitoring ECT on two channels. ECT machines were regularly maintained and a record of maintenance was kept. The last check was carried out in September 2018 by cardiac services. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. There was an updated guidance document for crisis anaesthesia in the approved centre updated in 2018. There were at least two registered nurses in the ECT suite at all times, one of whom was a designated ECT nurse.

The approved centre was non-compliant with this code of practice because not all staff involved in ECT had appropriate training and education in Basic Life Support techniques, 11.7.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate policies in relation to admission, transfer, and discharge. The admission policy had been approved in October 2018 while the Transfer and Discharge policies had been approved in May 2018. The Admission policy did not include specific reference or oversight in relation to referral letters for admission.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission and transfer policy. There was no documentary evidence that relevant staff had read and understood the discharge policy.

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

Evidence of Implementation:

Admission: A key worker in place for the admission of residents to the approved centre. Admission was on the basis of a mental illness or mental disorder. Admission assessments were completed and included presenting problem, past psychiatric history, family history, and medical history. A full physical examination was undertaken at admission.

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

Discharge: Full discharge plans in the approved centre included the following: estimated date of discharge; documented communication with the relevant general practitioner, primary care team, and/or Community Mental Health Team (CMHT); a follow up plan; and a reference to early warning signs of relapse and risks.

The discharge meeting was attended by residents, the relevant key worker, relevant members of the multi-disciplinary team (MDT), and family carer or advocate, where appropriate and with the consent of the resident.

Discharge assessments addressed psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, and informational needs. Discharge was coordinated by the designated key worker. Discharge summaries included details of diagnosis, prognosis, and medication. A family member, carer, or advocate was involved in the discharge process, where appropriate. A timely follow up appointment was organised, where there was a recent history of self-harm or a suicide risk, within one week.

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

a) The admission policy did not outline procedure in relation to referral letters, 4.3
b) Documentary evidence that staff had read and understood the discharge policy was lacking, 9.1

c) Audits of the implementation of admission and discharge policies had not been completed, 4.19.
<table>
<thead>
<tr>
<th>Reason ID : 10000342</th>
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<tbody>
<tr>
<td><strong>Regulation 11: Visits</strong></td>
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<tr>
<td>The designated visitors room was not always available for children visiting, which meant there were not always appropriate arrangements and facilities in place for children visiting a resident, 11 (5).</td>
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<tr>
<th>Specific</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
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<tr>
<td><strong>Corrective Action</strong></td>
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<tr>
<td>The visiting room in the Comeragh unit, D.O.P. is available at all times to facilitate children visiting a resident. Signage to demonstrate this has been put in place.</td>
<td>The availability of the visitor's room to facilitate child visiting will be monitored by the CNM as required when there is a need to facilitate children. Compliance with visiting regulation will be monitored as part of the DOP UHW annual audit schedule. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>09/09/2019</td>
<td>ADON/CNM</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
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<tr>
<td>A memo will be sent to all MDT members via HODs to reiterate the necessity to facilitate children visiting at all times. The visiting room can only be used by MDTs when not required for visiting.</td>
<td>On-going monitoring of visiting room availability will be carried out by CNMs. Compliance with Regulation 11 Visits will be monitored as part of the DOP UHW annual audit schedule. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>09/09/2019</td>
<td>HODs</td>
</tr>
</tbody>
</table>
**Regulation 25: Use of Closed Circuit Television**

**Reason ID : 10000343**

The CCTV monitor located in the nurses' office was not viewed only by the health professional responsible for the health and welfare of the resident. It was visible to the public and anyone passing the nurses' office could potentially see the monitor and CCTV images, 25(1).

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</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The CCTV monitor was moved to ensure that only health care professionals can view images in April 2019.</td>
<td>Complete</td>
<td>Achievable and Realistic</td>
<td>09/09/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>External CCTV contract company has been contacted and requested to provide a means of ensuring that the monitor is fixed in its current position and cannot be moved.</td>
<td>The CNM on duty each day is responsible for ensuring the CCTV monitor can only be viewed by health care professionals. Compliance with Regulation 25 CCTV will be monitored annually as part of the DOP audit schedule. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>09/10/2019</td>
</tr>
</tbody>
</table>
## Regulation 28: Register of Residents

| Reason ID | The register did not contain all of the information specified under Schedule 1, 28 (2), due to the following:  
|           | a) Diagnosis on admission or provisional diagnosis was not documented.  
|           | b) Resident status (voluntary or involuntary) was not documented on the register.  
|           | c) Discharge diagnosis was not consistently documented. |

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<th>Achievable/Realistic</th>
<th>Time-bound</th>
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</table>
| Corrective Action | All information specified under Schedule 1, 28 (2) including: a) Diagnosis on admission or provisional diagnosis  
|          | b) Resident status (voluntary or involuntary)  
|          | c) Discharge diagnosis are now recorded within the DOP Register of Residents. | A weekly review of the Register of residents is carried out by the Ward Clerk overseen by the Senior Administrator to ensure completeness of the register in line with Schedule 1 28 (2). Oversight and governance will be provided through the DOP QPSC. | Achievable and realistic | 09/09/2019 | Senior Administrator and Ward Clerk |
| Preventative Action | A weekly review of the Register of residents is carried out by the Ward Clerk overseen by the Senior Administrator to ensure completeness of the register in line with Schedule 1 28 (2).  
|          | Compliance with Regulation 28 will be monitored annually as part of the DOP Audit Schedule. Audit of Compliance with Regulation 28 was last audited July 2019 and action plan implemented. Oversight and governance will be provided through the DOP QPSC. | A weekly review of the Register of residents is carried out by the Ward Clerk overseen by the Senior Administrator to ensure completeness of the register in line with Schedule 1 28 (2).  
<p>|          | Compliance with Regulation 28 will be monitored annually as part of the DOP Audit Schedule. Audit of Compliance with Regulation 28 was last audited July 2019 and action plan implemented. Oversight and governance will be provided through the DOP QPSC. | Achievable and realistic | 19/07/2019 | Senior Administrator and Ward Clerk |</p>
<table>
<thead>
<tr>
<th>Regulation 19 General Health</th>
<th>One resident did not receive a six-month general health check within the required timeframe, 19 (1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific: This resident received a six-month general health check in April 2019 once it was identified as due.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Specific: A flagging system is now in place whereby all residents who are due general health check in line with Regulation 19 are identified and this need is communicated to the relevant medical team at bed management meetings.</td>
</tr>
<tr>
<td><strong>Reason ID : 10000355</strong></td>
<td>Specific: Not all six monthly general health checks were completed in full. Physical examinations were inadequate, and did not consistently include an assessment of residents' Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, and dental health, 19 (1)(b).</td>
</tr>
</tbody>
</table>
**Corrective Action**

An audit of General Health Assessments will take place on 13/09/2019. Where assessments have not recorded an assessment of residents' Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, and dental health, 19 (1)(b), this will be completed in full.

The completion in full of General Health Assessments will be measured through audit 13/09/2019 and any non compliance addressed immediately. Oversight and governance will be provided through the DOP QPSC.

Achievable and Realistic 13/09/2019 Compliance Officer/Medical Practitioner

<p>| Preventative Action | A flagging system is now in place whereby all residents who are due general health check in line with Regulation 19 are identified and this need is communicated to the relevant medical team at bed management meetings. A new General Health Assessment Form which records all required assessments under Regulation 19 is now in place. General Health Assessments will be checked for completeness biannually. Any non compliance will be addressed immediately. General Health Assessments will be audited biannually to measure compliance with Regulation 19 and any non compliance addressed immediately. Oversight and governance will be provided through the DOP QPSC. Achievable and Realistic 13/09/2019 Treating Consultant/NC HD |</p>
<table>
<thead>
<tr>
<th>Reason ID: 10000357</th>
<th>Residents in the approved centre were not provided with adequate emergency clothing, with due regard to his or her dignity and bodily integrity at all times, 7 (1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>An adequate supply of emergency clothing, with due regard to dignity and bodily integrity, has been obtained and is now in place. An educational session took place with relevant nursing staff which included review of the Clothing Policy on 22/08/2019.</td>
</tr>
<tr>
<td></td>
<td>The supply of emergency clothing is evident on site. An audit of clothing was carried out on the 22/08/2019 and action plan implemented. Oversight and governance will be provided through the DOP QPSC.</td>
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<td></td>
<td><strong>Achievable/Realistic</strong></td>
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<tr>
<td></td>
<td>Achievable and Realistic</td>
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</table>

| **Preventative Action** | A monitoring system is now in place. On a weekly basis, stock supply of emergency clothing is checked and where additional supply is required, this is ordered. |
| A monitoring system is now in place. On a weekly basis, stock supply of emergency clothing is checked and where additional supply is required, this is ordered. Compliance with Regulation 7 Clothing will be monitored as part of the Annual DOP Audit Schedule. Oversight and governance will be provided through the DOP QPSC. |
| **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| Achievable and Realistic | 22/08/2019 | CNMs |
### Regulation 8 Residents' Personal Property and Possessions

**Reason ID: 10000358**

The registered proprietor did not ensure that an accurate record was maintained of each resident's personal property and possessions. Cash balance did not always correspond with the balance recorded in available records, 8(3).

<table>
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<tr>
<th>Corrective Action</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
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<tbody>
<tr>
<td></td>
<td>Once identified, a review of the relevant cash records took place.</td>
<td>Achievable and Realistic</td>
<td>14/06/2019</td>
<td>ADON/CNMs/Relevant Administrative Staff</td>
</tr>
<tr>
<td></td>
<td>New cash recording documentation was implemented, supported by a DOP Residents Property Protocol in April 2019. 10 training sessions on Resident's Personal Property and Possessions (Reg 8) and the new DOP Residents Property Protocol took place with 43 nursing and administrative staff. Arrangements for safe keeping of cash sums are now in place.</td>
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<td></td>
<td>An audit of Resident's Personal Property and Possessions (Reg 8) took place in July 2019 to measure compliance with Regulation and local protocol. Any non compliance was addressed. Oversight and governance will be provided through the DOP QPSC.</td>
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<td>New cash recording documentation was implemented, supported by a DOP Residents Property Protocol in April 2019. 10 training sessions on Resident's Personal Property and Possessions (Reg 8) and the new DOP Residents Property Protocol took place with 43 nursing and administrative staff. Arrangements for safe keeping of cash sums are now in place.</td>
<td>Achievable and Realistic</td>
<td>14/06/2019</td>
<td>ADON/CNMs/Relevant Administrative Staff</td>
</tr>
<tr>
<td></td>
<td>Audits of Resident's Personal Property and Possessions (Reg 8) will take place annually as part of the DOP Audit Schedule. Last audit was carried out 22/08/2019. Oversight and governance will be provided through the DOP QPSC.</td>
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Provisions were not made for the safe-keeping of each resident's personal property and possessions. Residents' property was stored in property areas within the approved centre but was not labelled and the property owner was not identifiable, 8 (6).

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<tr>
<td><strong>Corrective Action</strong></td>
<td>33 Nursing staff have received training in Reg 8 Resident's Personal Property and Possessions in June 2019. This training addressed the requirement to label all property stored in the property areas of the D.O.P. All property stored in property areas are now labelled to ensure the owner is identifiable.</td>
<td>The labelling of residents' property stored in the property area is monitored on an ongoing basis by CNMs. An audit of Reg 8 Resident's Personal Property and Possessions took place in August 2019 and any issues addressed. Reg 8 Resident's Personal Property and Possessions will be audited annually as part of the DOP Audit Schedule. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>14/06/2019</td>
<td>CNMs</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>33 Nursing staff have received training in Reg 8 Resident's Personal Property and Possessions in June 2019. All property stored in property areas are now labelled to ensure the owner is identifiable.</td>
<td>The labelling of residents' property stored in the property area is monitored on an ongoing basis by CNMs. An audit of Reg 8 Resident's Personal Property and Possessions took place in July 2019 and any issues addressed. Reg 8 Resident's Personal Property and Possessions will be audited annually as part of the DOP Audit Schedule. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>14/06/2019</td>
<td>CNMs</td>
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<tr>
<td>Corrective Action</td>
<td>Specific</td>
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<tr>
<td><strong>Regulation 13: Searches</strong></td>
<td>Not all searches were undertaken with due regard to the resident's dignity, privacy, and gender. At least one staff member was not the same gender as the resident being searched, 13 (7).</td>
<td>A record of attendance at Regulation 13 Searches briefing session will be maintained. Oversight and governance will be provided through the DOP QPSC. Regulation 13 Searches will be audited annually as part of the DOP Audit Schedule to measure compliance and any non compliance will be addressed.</td>
<td>Achievable and Realistic</td>
<td>13/09/2019</td>
<td>Compliance Officer/CNMs</td>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
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<tr>
<td>A Regulation 13 Searches briefing session is scheduled for 18/09/2019. This session will reiterate the requirement to carry out all searches with due regard to the resident's dignity, privacy, and gender and the requirement for at least one staff member to be the same gender as the resident being searched, 13 (7).</td>
<td>A record of attendance at Regulation 13 Searches briefing session will be maintained. Regulation 13 Searches will be audited annually as part of the DOP Audit Schedule to measure compliance and any non compliance will be addressed.</td>
<td>Achievable and Realistic</td>
<td>13/09/2019</td>
<td>Compliance Officer/CNMs</td>
<td></td>
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</table>
gender as the resident being searched, 13 (7). CNM will also send notification to all DOP staff to reiterate the requirement to carry out all searches with due regard to the resident's dignity, privacy, and gender and the requirement for at least one staff member to be the same gender as the resident being searched, 13 (7).

The written record of the search inspected did not document the reasons for, and who participated in, the search, 13 (8).

<table>
<thead>
<tr>
<th>Reason ID : 10000361</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oversight and governance will be provided through the DOP QPSC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Regulation 13 Searches briefing session is scheduled for 18/09/2019. This session will reiterate the requirement to document within the Searches Log the reason for and who participated in the search, 13 (8). CNM will also send notification to all DOP staff to reiterate the requirement to document the reason for and who participated in the search, 13 (8) within the DOP Searches Log. The Searches Log template has been updated to ensure all required information including the requirement to document the reason for and who participated in the search are recorded.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
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</thead>
<tbody>
<tr>
<td>A Regulation 13 Searches briefing session will be maintained. The updated Searches Log Template is uploaded for review. Each search record will be reviewed by ADON to ensure compliance with Regulation 13 Searches. Governance and oversight will be provided through DOP QPSC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievable/Realistic</th>
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<tbody>
<tr>
<td>Achievable and Realistic</td>
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<tr>
<th>Time-bound</th>
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<tbody>
<tr>
<td>13/09/2019</td>
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<table>
<thead>
<tr>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance Officer/ CNM/ADON</td>
</tr>
<tr>
<td>Preventative Action</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

#### Reason ID: 10000369

The approved centre was not adequately clean. Bins were overflowing in both the male and female toilets in Comeragh Unit. There were discarded cigarette butts in the sink of the ladies communal toilet in Comeragh Unit. The bath within the assisted bathroom on Brandon Unit was dirty. Thick cobwebs were observed on the ceiling in Brandon Unit, 22 (1a).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The following issues were resolved during MHC inspection; Overflowing bins in both the male and female toilets in Comeragh Unit, unclean bath and cigarette butts in the sink of the ladies communal toilet in Comeragh Unit.</td>
<td>Visual inspection by ADON confirmed issues were addressed in full.</td>
<td>Achievable and Realistic</td>
<td>16/04/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Monthly hygiene audits take place with a minimum of 85% compliance with hygiene standards accepted. Additional cleaning is requested where agreed inputs are not delivering the required hygiene standards.</td>
<td>Monthly hygiene audits are conducted and issues identified are addressed. Governance and oversight is provided through DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>16/04/2019</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000370

The approved centre environment was not developed with due regard to the specific needs and well-being of residents. Residents had no access to outdoor space on Brandon Unit, 22 (3).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Residents had no access to outdoor space on Brandon Unit, 22 (3), due to temporary works required to develop the unit. The garden space was reopened within days of the inspection.</td>
<td>Access to garden is evident.</td>
<td>Complete</td>
<td>30/05/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>There are no further works planned which would hamper</td>
<td>Access to garden is evident.</td>
<td>Complete</td>
<td>30/05/2019</td>
</tr>
<tr>
<td>Reason ID : 10000371</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>The premises was not maintained in good decorative condition; furniture upholstery within Comeragh Unit visiting room was significantly worn and damaged, 22 (1)(a).</td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A programme of decorative works is ongoing in the DOP and recorded in the Maintenance Governance Checklist. The furniture with worn upholstery within Comeragh Unit visiting room is being replaced. The order has been finalised with anticipated 12 week delivery time.</td>
<td>The progress of the programme of decorative works will be monitored through DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>02/12/2019</td>
<td>ADON/Service Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A programme of decorative works is ongoing in the DOP. Monthly Unit Walkrounds by ADON, Service Manager and Technical Services Representative will identify issues such as worn furniture upholstery. All issues identified through unit walkabouts will be addressed. Governance and oversight will be provided through QPSC.</td>
</tr>
</tbody>
</table>
Regulation 21: Privacy

<table>
<thead>
<tr>
<th>Reason ID : 10000374</th>
<th>The registered proprietor did not ensure that the residents' privacy and dignity was appropriately respected at all times; Comeragh Unit garden area was overlooked by a public area.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Options for providing screening for the Comeragh Unit garden area are being explored and costings will be submitted to Service Management for approval.</td>
<td>Screening will be evident when in place. Progress of implementation will be monitored through QPSC.</td>
<td>Achievable and Realistic</td>
<td>09/11/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Options for providing screening for the Comeragh Unit garden area are being explored and costings will be submitted to Service Management for approval.</td>
<td>Screening will be evident when in place. Progress of implementation will be monitored through QPSC.</td>
<td>Achievable and Realistic</td>
<td>09/11/2019</td>
</tr>
<tr>
<td>Reason ID : 10000345</td>
<td>The admission policy did not outline procedure in relation to referral letters, 4.3.</td>
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<td>---------------------</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific: The requirement for referral letters has been added to the Waterford/Wexford Mental Health Services Admission Policy. This draft policy will be reviewed by the Senior Management Team for approval on 19/09/2019.&lt;br&gt;MHSC Policy Group/Senior Management Team&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 19/09/2019&lt;br&gt;</td>
<td>Measurable: The review and approval of all policies including the Admission Policy is monitored by the Chair of SECH PPPG.&lt;br&gt; SECH PPPG&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 19/09/2019&lt;br&gt; Post-Holder(s): SECH Policy Group/Senior Management Team</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific: All new policies including the Admission Policy will be checked prior to submission for approval for compliance with relevant Mental Health Regulation, Code of Practice and Rules.&lt;br&gt; SECH PPPG&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 19/09/2019&lt;br&gt; Post-Holder(s): SECH PPPG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason ID : 10000346</strong></td>
<td>Documentary evidence that staff had read and understood the discharge policy was lacking, 9.1</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific: All members of the MDT will be directed to read the discharge policy and sign to indicate that they have read and understood the policy. A record of signatures will be maintained in the DOP.&lt;br&gt;HODs/MDT members&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 09/11/2019&lt;br&gt; Post-Holder(s): HODs/MDT members</td>
</tr>
<tr>
<td></td>
<td>Measurable: A record of signatures will be maintained in the DOP. Oversight and governance will be provided through the DOP QPSC&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 09/11/2019&lt;br&gt; Post-Holder(s): HODs/MDT members</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific: Signatures on policy sign off sheets will be monitored monthly by the Compliance Officer and members of the MDT who have not signed the Discharge policy will be requested to do.&lt;br&gt; Compliance Officer/MDT members&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 09/11/2019&lt;br&gt; Post-Holder(s): Compliance Officer/MDT members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Measurable: A record of signatures will be maintained in the DOP. Oversight and governance will be provided through the DOP QPSC&lt;br&gt; Achievable and Realistic&lt;br&gt; Time-bound: 09/11/2019&lt;br&gt; Post-Holder(s): Compliance Officer/MDT members</td>
</tr>
</tbody>
</table>
Reason ID: 10000347

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Audits of the implementation of admission and discharge policies had not been completed, 4.19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Audits of Admissions and Discharge now take place as part of the DOP Annual Audit Schedule. Last audit was carried out July 2019.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Audit reports are held in a folder in the DOP. Audit findings are disseminated to the QPSC and actioned. Oversight and governance will be provided through the DOP QPSC.</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>Achievable and realistic.</td>
</tr>
<tr>
<td>Time-bound</td>
<td>19/07/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>ADON/CNM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Audits of Admissions and Discharge now take place as part of the DOP Annual Audit Schedule. Last audit was carried out July 2019.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Audit reports are held in a folder in the DOP. Audit findings are disseminated to the QPSC and actioned. Oversight and governance will be provided through the DOP QPSC.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Achievable and realistic.</td>
</tr>
<tr>
<td>Time-bound</td>
<td>19/07/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>ADON/CNM</td>
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</tbody>
</table>
### Code of Practice on the Use of Physical Restraint in Approved Centres

<table>
<thead>
<tr>
<th>Reason ID : 10000348</th>
<th>For two of three episodes of physical restraint reviewed, there was no evidence in support of a physical examination being carried out on the resident no later than three hours after the start of the episode of physical restraint, 5.4.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A medical examination of the two residents took place, though outside of the required 3 hour time frame. A new Physical Restraint Checklist has been implemented to ensure this requirement is met within the 3 hours required.</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>The medical examination of residents is evident in the healthcare records. Episodes of Physical Restraint will be audited as part of the DOP Audit Schedule. Oversight and governance will be provided through the DOP QPSC.</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>19/04/2019</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>Treating Consultant/NCHD</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td></td>
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</tbody>
</table>

| **Preventative Action** | A new Physical Restraint Checklist has been developed which identifies the requirement for physical examination within 3 hours of the episode of physical restraint. This is being reviewed by the Senior Management Team 19th September 2019 and has been circulated to DOP staff members to be implemented on a trial basis pending approval. |
| **Specific** | The new Physical Restraint Checklist as uploaded to CIS has been circulated to relevant staff members. |
| **Measurable** | Achievable and Realistic |
| **Achievable/Realistic** | 19/09/2019 |
| **Time-bound** | Nurse Practice Development Coordinators/DOP Medical and Nursing Staff |
| **Post-Holder(s)** |  |

<table>
<thead>
<tr>
<th>Reason ID : 10000349</th>
<th>There was no evidence that the resident had been informed of the reason for and likely duration of restraint in all cases, 5.8.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A new Physical Restraint Checklist has been developed which identifies the requirement to inform the resident of the</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>The new Physical Restraint Checklist as uploaded to CIS has been circulated to relevant staff members.</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>19/09/2019</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>Nurse Practice Development Coordinators/</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Physical Restraint episodes will be audited as part of the DOP audit schedule. Oversight and governance will be provided through the DOP QPSC.</td>
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<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Corrective Action</td>
<td>A new Physical Restraint Checklist has been developed which identifies the requirement to inform the resident's next of kin of the episode of physical restraint, or to document the rationale if not. This is being reviewed by the Senior Management Team 19th September 2019 and has been circulated to DOP staff members to be implemented on a trial basis pending approval.</td>
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</tbody>
</table>

Reason ID : 10000350

In one case reviewed, the resident's next of kin was not informed or, if not done, explanation as to why this was the case, 5.9.

<table>
<thead>
<tr>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A new Physical Restraint Checklist has been developed which identifies the requirement to inform the resident's next of kin of the episode of physical restraint, or to document the rationale if not. This is being reviewed by the Senior Management Team 19th September 2019 and has been circulated to DOP staff members</td>
<td>The Physical Restraint Checklist as uploaded to CIS has been disseminated to all relevant staff and implemented on a trial basis pending Senior Management Team approval. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>19/09/2019</td>
<td>NPDC/Medical and Nursing Staff</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>A new Physical Restraint Checklist has been developed which identifies the requirement to inform the resident's next of kin of the episode of physical restraint, or to document the rationale if not. This is being reviewed by the Senior Management Team in September 2019 and has been circulated to DOP staff members to be implemented on a trial basis pending approval.</td>
<td>The Physical Restraint Checklist as uploaded to CIS has been disseminated to all relevant staff and implemented on a trial basis pending Senior Management Team approval. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>19/09/2019</td>
</tr>
<tr>
<td>COP on the Use of ECT for Voluntary Patients and Rule on the Use of ECT (Section 59)</td>
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<tr>
<td><strong>Reason ID : 10000362</strong></td>
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</tr>
<tr>
<td><strong>Not all staff involved in ECT had received appropriate training and education in Basic Life Support techniques, (10.7)(11.7).</strong></td>
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<tr>
<td><strong>Corrective Action</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>All 14 ECT trained staff will have up to date BLS training 27/09/2019. There is a schedule in place to address the training needs of the two remaining ECT trained Nurse.</td>
<td></td>
<td></td>
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<tr>
<td><strong>Measurable</strong></td>
<td>The ECT lead will monitor the BLS training of ECT trained Nursing staff</td>
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<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Achievable and Realistic</td>
<td></td>
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<tr>
<td><strong>Time-bound</strong></td>
<td>27/09/2019</td>
<td></td>
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<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>ADON Responsible for Training/ECT Lead Nurse.</td>
<td></td>
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<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>The ECT lead will monitor the BLS training of ECT trained Nursing staff in collaboration with the ADON responsible for training.</td>
<td></td>
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</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>BLS Training checklist is in place for ECT trained staff in the DOP.</td>
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<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Achievable and Realistic</td>
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<tr>
<td><strong>Time-bound</strong></td>
<td>27/09/2019</td>
<td></td>
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<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>ECT Lead/ADON</td>
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</tbody>
</table>
### COP Relating to Admission of Children under the Mental Health Act 2001.

**Reason ID : 10000363**

The policy did not detail the requirement for each child to be individually risk-assessed, 2.5 (i). The policy did not address the procedures in relation to family liaison, parental consent, and confidentiality, 2.5 (l).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Child Admissions Policy has been updated to include the requirement for each child to be individually risk-assessed, 2.5 (i) and the procedures in relation to family liaison, parental consent, and confidentiality, 2.5 (l). See same uploaded. It will be reviewed with a view to approval by Senior Management Team on 19/09/2019.</td>
<td>The review and approval of all policies including Child Admissions is monitored by the Chair SECH PPPG.</td>
<td>There have been ongoing difficulties in identifying &quot;Treating Consultants&quot; for admitted children due to recruitment and retention challenges of candidates from the specialist register for CAMHS. The inability to identify clear responsibility for the care and treatment of admitted children has impacted on our ability to approve and implement a revised Childs Admission Policy.</td>
<td>19/09/2019</td>
<td>SECH PPPG / Senior Management Team</td>
</tr>
</tbody>
</table>

| Preventative Action | All revised policies including Child Admission Policy will be checked for compliance with Mental Health Regulations, COP and Rules prior to submission for approval. | The review and approval of all policies including Child Admissions is monitored by the Chair SECH PPPG. | Achievable/ and Realistic | 19/09/2019 | SECH PPPG |

**Reason ID : 10000365**

There were no specific provisions in place to ensure the rights of the child to have their views heard, 2.5 (c) (iii).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The QPSC have liaised with Youth advocate programme Ireland. One meeting has been QPSC awaiting confirmation to proceed for EMT. The proposal is</td>
<td>Achievable and Realistic</td>
<td>01/12/2019</td>
<td>QSEC/EMT</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>QPSC awaiting confirmation to proceed from EMT. The proposal is for the provision of an Independent Advocacy Service. This proposal includes the provision of an Independent Advocate (YAP Ireland Team Leader staff level) for 1.5 days per week. This service would be offered on site at the DOP UHW.</td>
<td>The introduction of external Youth advocate programme Ireland would be monitored and overseen through QPSC DOP UHW to ensure specific provisions are in place to ensure the rights of the child to have their views heard. Monthly-YAP Ireland Service Manager will meet with the nominated staff member from DOP UHW, Quarterly-YAP Ireland Director of Services and DOP UHW, steering group will review reports on progress and outcomes achieved. Review service and resolve any issues that arise.</td>
<td>Achievable and Realistic</td>
<td>01/12/2019</td>
<td>QPSC/QSEC/EMT</td>
</tr>
</tbody>
</table>

Reason ID: 10000366  
Child residents did not have access to age-appropriate advocacy services, 2.5 (g).

<table>
<thead>
<tr>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>The QPSC have liaised with Youth advocate programme</td>
<td>QPSC awaiting confirmation to proceed</td>
<td>Achievable and Realistic</td>
<td>01/12/2019</td>
</tr>
</tbody>
</table>
Ireland. One meeting has been held to identify the DOP UHW needs. A proposal has been received and reviewed by QPSC. The proposal has been forwarded to Service Management for consideration.

Preventative Action

QPSC awaiting confirmation to proceed for EMT. The proposal is for the provision of an Independent Advocacy Service. This proposal includes for providing an Independent Advocate (YAP Ireland Team Leader staff level) for 1.5 days per week. This service would be offered on site at the DOP UHW.

Monthly-YAP Ireland Service Manager will meet with the nominated staff member from DOP UHW. Quarterly-YAP Ireland Director of Services and DOP UHW, steering group will review reports on progress and outcomes achieved. Review service and resolve any issues that arise.

Achievable and Realistic

Reason ID: 10000367

Corrective Action

In the event of the admission of a child to the DOP, a referral will be made to the OT Department to engage with the young person to develop an age appropriate individualised therapeutic programme. A memo will be sent by the ECD to treating consultants to reiterate.

The provision of appropriate individualised therapeutic programme for children admitted to the DOP will be monitored through quarterly ICP audits. Governance and oversight provided by DOP QPSC.

Achievable and Realistic

Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre, 2.5 (b).

Specific | Measurable | Achievable/Realistic | Time-bound | Post-Holder(s) |
---|---|---|---|---|
Corrective Action |  | Achievable and Realistic | 09/10/2019 | Occupational Therapy staff working in the DOP, UHW/ ECD/Treating Consultants |

Reason ID: 10000367
the requirement for OT referral for any child admitted to the DOP.

Preventative Action

| Preventative Action | A memo will be sent by the ECD to treating consultants to reiterate the requirement for OT referral for any child admitted to the DOP. Occupational therapy staff based at the DOP, UHW will assess children admitted there and devise a programme of activities appropriate to their age and ability. | The provision of appropriate individualised therapeutic programme for children admitted to the DOP will be monitored through quarterly ICP audits. Governance and oversight provided by DOP QPSC. | Achievable and Realistic | 09/10/2019 | Occupational Therapy staff working in the DOP, UHW/ ECD/ Treating Consultants |

Reason ID : 10000368

| Corrective Action | All staff have completed Children's First Training. Appropriate training relating to the care of children, 2.5 (e). will be sourced and provided where possible. | Training records are available for review. | Unknown at present pending identification of potential training media. | 10/02/2020 | Compliance Officer/HoDs |

| Preventative Action | All staff have completed Children's First Training. Appropriate training relating to the care of children, 2.5 (e). will be sourced and provided where possible. | Training records are available for review. | Unknown at present pending identification of potential training media. | 10/02/2020 | Compliance Officer/HoDs |
### Rules Governing the Use of Seclusion

#### Reason ID: 10000351

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>All relevant members of the MDT will be directed to read the Seclusion policy and sign to indicate that they have read and understood the policy. A record of signatures will be maintained in the DOP.</td>
<td>A record will be kept on site in the DOP UHW.</td>
<td>Achievable and Realistic</td>
<td>10/11/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Signatures on policy sign off sheets will be monitored monthly by the Compliance Officer and members of the MDT who have not signed will be requested to so.</td>
<td>A record will be kept on site in the DOP UHW. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>10/11/2019</td>
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</tbody>
</table>

#### Reason ID: 10000352

<table>
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<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>A Seclusion Pack has been developed and implemented in the DOP UHW to ensure that all patients are informed of the ending of seclusion.</td>
<td>A Seclusion audit will be carried out on 13/09/2019 and monthly in line with the audit schedule for the DOP UHW.</td>
<td>Achievable and Realistic</td>
<td>13/09/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>A resource folder has been developed and introduced to support Nursing staff in the DOP. MDT Training has been provided on the Rules Governing Seclusion May/June 2019 in the DOP UHW. Full implementation of the Seclusion Pack and Checklist will prevent non-compliance.</td>
<td>A Seclusion audit will be carried out on 13/09/2019 and monthly in line with the audit schedule for the DOP UHW.</td>
<td>Achievable and Realistic</td>
<td>13/09/2019</td>
</tr>
<tr>
<td>Reason ID : 10000353</td>
<td>It was not evident that all episodes of seclusion were reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days of the episode, 10.3.</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>A Seclusion Pack has been developed and implemented in the DOP UHW to ensure that all patients are reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days of the episode, 10.3.</td>
<td>A seclusion audit will be carried out on 13/09/2019 and monthly in line with the audit schedule for the DOP UHW. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Achievable and Realistic</td>
<td>13/09/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>A seclusion audit will be carried out 13/09/2019 and monthly in line with the audit schedule for the DOP UHW. Non compliance with the Rules of Seclusion will be brought to the attention of relevant staff and corrected where possible. Oversight and governance will be provided through the DOP QPSC.</td>
<td>Monthly seclusion audits will be carried out in line with the audit schedule for the DOP UHW with oversight by QPSC.</td>
<td>Achievable and Realistic</td>
<td>13/09/2019</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, 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.