

## Department of Psychiatry, Waterford University Hospital

**ID Number:** AC0034

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

**Department of Psychiatry**  
Waterford University Hospital  
Ardkeen  
Waterford

**Approved Centre Type:**  
Acute Adult Mental Health Care

**Most Recent Registration Date:**  
1 March 2014

**Conditions Attached:**  
None

**Registered Proprietor:**  
HSE

**Registered Proprietor Nominee:**  
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**Inspection Team:**  
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**Inspection Date:**  
24 – 25 January 2017

**Previous Inspection Date:**  
13 – 14 July 2016

**Inspection Type:**  
Focused Inspection

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

**Date of Publication:**  
31 August 2017



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# 1.0 Focused 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.

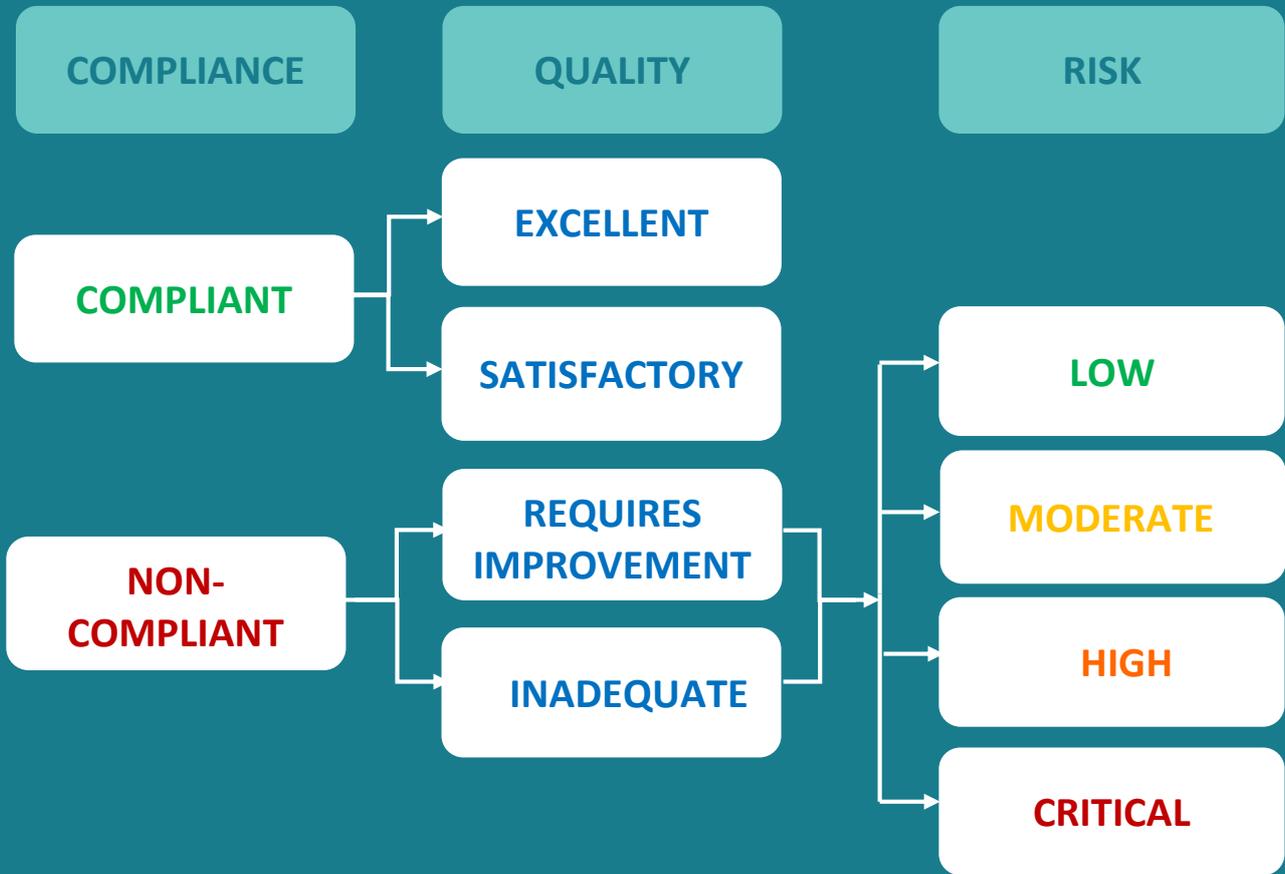
The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres.

In addition to the principal function of the Inspector of Mental Health Services under Section 51 of the Mental Health Act 2001 to inspect every approved centre at least once a year (and other mental health services, as appropriate), the Inspector may also undertake a focused inspection.

During a focused inspection, the Inspector may visit and inspect any premises where mental health services are provided and make a report in writing to the Commission to ascertain whether or not due regard is being had to the Mental Health Act 2001 and its provisions.

## COMPLIANCE, QUALITY AND RISK RATINGS

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



## 2.0 Focused Inspection – Department of Psychiatry, University Hospital Waterford

### 2.1 Background and scope of focused inspection

This focused inspection was a follow-up to both the annual inspection of the Department of Psychiatry, Waterford University Hospital, 11 – 13 May 2016, and the focused inspection, 13 – 14 July 2016. It had a broad perspective on patient safety and care.

The inspection 11-13 May 2016 identified 20 areas of statutory non-compliance. Five of these were rated critical:

- Regulation 9: Recreational Activities.
- Regulation 16: Therapeutic Services and Programmes.
- Regulation 21: Privacy.
- Rules Governing the Use of Seclusion.
- Part 4 of the Mental Health Act 2001: Consent to Treatment.

The approved centre was required to provide a Corrective and Preventative Action Plan (CAPA) to the Mental Health Commission (MHC) to address each area of non-compliance. The MHC issued a serious concern immediate action notification to the registered proprietor on 25 May 2016 in respect of the following:

- The use of seclusion.
- The provision of recreational activities.
- The provision of therapeutic services and programmes.
- Sleeping accommodation and the provision of adequate privacy.

The focused inspection in July 2016, specifically examined recreation, therapeutic services and programmes, privacy, and seclusion. At this time, the inspectors noted that the staffing level on the second day of inspection comprised three nurses for 32 residents on the Sub-Acute Unit. The serious concerns arising out of the July 2016 focused inspection included the following:

- The safety and suitability of the premises, including ligature anchor points in both the Acute and Sub-Acute Units.
- The lack of facilities in the Acute Unit, including no dining area or communal seating area.
- The inadequate protection of residents' privacy in the Acute Unit.
- The lack of recreational facilities in the Acute Unit.
- The inadequate provision of therapeutic services and programme provision to residents in the Acute Unit.
- The insufficient staffing levels.
- The intention to expand the 10-bed Acute Unit to a 14-bed unit, despite the lack of adequate facilities and inadequacies in the provision of therapeutic services.

In 2016, the MHC required the registered proprietor to provide monthly CAPA reports in relation to the critically rated areas of non-compliance and the proposed refurbishment works. These included the registered proprietor's considerations and plans for ensuring resident safety and care during the refurbishment works.

## 2.2. Focus of inspection

In the period from January 2016 to January 2017, there had been two deaths, both suspected cases of suicide, in the Department of Psychiatry (DOP). Both occurred in lavatories in the Sub-Acute Unit.

At the time of the January 2017 focused inspection, refurbishment work was under way throughout the approved centre to remediate ligature anchor points in showers and lavatories and some window fittings. The refurbishment, which commenced in September 2016, also included the reconfiguration of the Acute Unit from a 10-bed to a 14-bed unit. It was a matter of concern that the approved centre had increased its bed numbers in the Acute Unit without having made provision for adequate living, recreational, or therapeutic facilities. This inspection had a broad focus on patient care and safety and included but was not limited to the following:

- Recreational facilities and resources.
- Care and treatment – Individual care planning and therapeutic services and programmes.
- Resident privacy and dignity.
- The safety and suitability of the premises.
- Staffing.
- Risk Management.

## 2.3 Description

The DOP was located on the ground floor of Waterford University Hospital, Ardkeen, Waterford city. The approved centre was easily accessed from the main hospital via a lift and stairs, and it was well signposted. The entrance doors to both the Sub-Acute Unit and the Acute Unit were locked throughout the inspection.

The DOP provided the acute in-patient psychiatric care for the adult population of parts of the HSE Community Healthcare Organisation (CHO) Area 5: Waterford, South Kilkenny, and South Wexford. The adult population served by the DOP was 286,000, comprising 136,000 for Waterford and South Kilkenny and 150,000 for Wexford. This constituted 17.5 acute mental health in-patient beds per 100,000 adult population.

Eight adult mental health teams, two Psychiatry of Later Life (POLL) teams, a mental health intellectual disability team, and rehabilitation teams each admitted residents to the DOP. Consequently, residents under the care of 13 different multi-disciplinary teams (MDTs) were admitted to the approved centre. Whilst in-patient in the DOP, Wexford residents were under the care of three locum consultant psychiatrists and a shared non-consultant hospital doctor who was allocated full-time to the approved centre. The exception to this was Wexford POLL residents who were looked after by the Waterford POLL team while they were in-patients in the DOP. In addition, where a child was admitted to the DOP because of a lack of child and

adolescent approved centre beds, the child and adolescent mental health consultant psychiatrist provided the in-patient care in the DOP.

The DOP had exceeded its 44-person bed capacity on six occasions since the date of the last focused inspection.

The approved centre had 44 beds arranged in two units, an Acute Unit and a Sub-Acute Unit. The configuration of these units had changed since the 2016 focused inspection. At that time, the Sub-Acute Unit had 34 beds and the Acute Unit had 10 beds. Building works had been completed to expand the floor space and bed capacity of the Acute Unit and reduce the floor space and bed capacity of the Sub-Acute Unit.

The Acute Unit now had an additional four beds, a universal-access toilet and shower, an assisted bathroom, and a new nursing office. The 14 beds in the unit comprised three 4-bed dormitories and two single rooms. The bedrooms were assigned as male or female. Otherwise, the unit remained as it was in 2016. It had a small outdoor area that essentially functioned as a smoking area and did not provide an attractive environment for residents. The Acute Unit did not have any dedicated dining, visiting, or communal seating area or social facilities for residents. It functioned as the admission unit. It also provided care and treatment for a small number of residents who required therapeutic containment and for a few residents whose discharges were protracted while they awaited suitable placements.

The Sub-Acute Unit's capacity had been reduced to 30 beds. It had a day activities area, a dining room-cum-sitting room, and a garden area. As each bedroom was being refurbished, the residents of that bedroom were temporarily required to sleep in the day activities room.

At the time of inspection, there were 40 residents in the approved centre. Two of these were children, another two had been in-patients for approximately six months, and two others had been in-patients for over a year. One-quarter of all residents were detained patients. There were two detained patients in the Sub-Acute Unit and eight in the Acute Unit. Special one-to-one nursing was being provided for four and five residents on day one and day two, respectively, of the inspection.

## 2.4 How the inspection was conducted

The inspection was conducted over two days. The inspection team walked throughout the approved centre and inspected the facility. It took photographic evidence of the premises where concerns or breaches of the applicable regulations were noted. The team read all relevant clinical and governance documentation, including policies, minutes of governance meetings, training records, and clinical files. The inspectors also met with staff, including;

- The Clinical Director,
- The Director of Nursing
- Assistant Director of Nursing X 2
- Day Activities Staff X 2
- Clinical Nurse Managers X 3
- Child and Adolescent Mental Health Service Consultant Psychiatrist
- Occupational Therapist

## 3.0 Findings

### 3.1 Resident interviews

The inspection team spoke individually with 11 residents.

Five residents in the Acute Unit stated that there was nothing to do and complained of boredom. One resident stated that they felt staff “brush me off” when the subject of activities and groups was raised. One resident said residents were treated “like children” when offered colouring pages to complete. Two residents said scheduled activities had been cancelled in the Acute Unit with no alternative offered. Two residents commented that activities such as jewellery making and yoga were available in the day activities area in the Sub-Acute Unit, but that residents of the Acute Unit who were not permitted to attend these did not have access to any activities. The residents in the Acute Unit said there was nowhere to go during the day other than to walk on the corridor or sit at their bedside. The residents in the Acute Unit stated that they felt safe.

Six residents in the Sub-Acute Unit were interviewed. Two residents stated that there were therapeutic activities during the week and they found these beneficial but that there were none at the weekend, which they considered “a shame”. Two residents said they did not feel safe at times in the Sub-Acute Unit.

### 3.2 Governance

The DOP was the acute adult mental health approved centre serving Waterford, Wexford, and South Kilkenny area, which are constituents of CHO 5. The CHO 5 Mental Health Service’s executive management team (EMT) was responsible for governance of the approved centre. The EMT comprised senior clinical and administrative staff of Waterford/Wexford Mental Health Services and included the executive clinical director, area director of nursing, area manager for mental health services, general manager, and heads of discipline for health and social care professionals. There was no service user representative on the EMT.

Meetings were held monthly, and issues discussed addressed all aspects of mental health services in the region and not just the Department of Psychiatry, Waterford University Hospital. There were relatively new post holders in the key roles of director of nursing and the assistant director of nursing with responsibility for the DOP. There was a Health and Safety Committee, which met quarterly, and a separate Quality and Safety Executive Committee (QSEC), which met monthly. Incident reports were reviewed by the QSEC and investigations were commissioned where required. The Policy Committee had not convened since July 2016. There was a weekly bed-management meeting held in the DOP and this was chaired by the executive clinical director.

### 3.3 Summary of findings

Considerable work had been completed in relation to the refurbishment of sleeping, toileting, and showering facilities. The remediation of ligature anchor points had progressed considerably. A ligature audit had been completed and risk was being mitigated by limiting the unsupervised access of residents to specific rooms and assigning beds according to individual risk management plans. Each resident was risk-assessed at the time of admission and each clinical file inspected contained a risk management plan. This inspection found the DOP compliant with Regulation 32: Risk Management Procedures. An additional clinical nurse manager 3 post had been put in place and two additional nurses were assigned to the DOP for the duration of the refurbishment works. Also, a dedicated activities nurse had been appointed to the Acute Unit. There were

plans to extend the Acute Unit and to provide a dining-cum-sitting room and an activity room. This process had gone to tender at the time of the inspection.

A number of issues had not been resolved, however. Concerns relating to ligature anchor points, inadequate facilities in the Acute Unit, and the upkeep of outdoor areas had all been consistently highlighted in inspection reports since 2012 and remained concerns. The DOP did not achieve regulatory compliance in the regulations listed below.

| Regulation   | Risk Rating | Reason for Non-Compliance   |
|--|-------------|---|
| Regulation 9: Recreational Activities              | High        | Inadequate access for Acute Unit residents to appropriate recreational activities   |
| Regulation 15: Individual Care Plan                | High        | <ul style="list-style-type: none"> <li>Two residents did not have an individual care plan (ICP).</li> <li>A number of the ICPs had not been developed and reviewed by the residents' multi-disciplinary teams.</li> </ul>   |
| Regulation 16: Therapeutic Services and Programmes | High        | Lack of adequate and suitable therapeutic services and programmes for residents in the Acute Unit.  |
| Regulation 21: Privacy                             | Moderate    | <ul style="list-style-type: none"> <li>There was inadequate privacy afforded to residents required to sleep in the day activity room on a temporary basis.</li> <li>One resident's bedroom door panel was not appropriately screened to ensure privacy.</li> </ul>                  |
| Regulation 22: Premises                            | High        | <ul style="list-style-type: none"> <li>Cramped and inadequate living facilities for residents in the Acute Unit.</li> <li>Incomplete ligature anchor point remediation work.</li> <li>Tardy management of waste bins and the implications of this for infection control.</li> </ul> |
| Regulation 26: Staffing                            | High        | Staff training was not up to date in mandatory areas.   |

## Regulation 9: Recreational Activities

**NON-COMPLIANT**

Risk Rating **HIGH**

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

**INSPECTION FINDINGS:** This regulation was inspected under evidence of implementation only.

**Evidence of Implementation:** Recreational provision was adequate for residents in the Sub-Acute Unit. It had a large activity room and a large day room-cum-dining room. Residents had access to televisions, a radio and music player, a DVD player, books, magazines, table games, and arts and crafts materials. At the time of the inspection, the mini-gym was out of commission because it was in a partitioned section of the activity room that was being used as a dormitory bedroom during renovation works. Recently purchased gym equipment, the existing exercise machines, and the table tennis table were all out of use for the same reason. There was an adequately sized garden just outside the day/dining room where residents could sit or walk. Residents were observed to be engaged in recreational activities during the course of the inspection. Each resident in the Sub-Acute Unit was risk-assessed in relation to leaving the unit and using the shop and food outlets in the main hospital concourse.

In the Acute Unit, recreational provision fell far short of what was reasonably practicable. At the time of inspection, the provision of recreational activities to the Acute Unit consisted of two table games, two adult colouring books, and a small set of paints and markers. These were located in an office and not readily available to residents on the unit. There was no dedicated room or space in the Acute Unit for residents to engage in recreational activity. There was neither adequate provision of materials nor facilities for recreation. There were televisions in the male and female dormitories but not in the two single rooms, whose residents had to go into the dormitories and sit adjacent to other residents' beds if they wished to watch television. Residents' choices for passing time were largely confined to spending their day lying on their bed, sitting on a hard chair by their bedside table, walking, or standing in the relatively small and cramped main hallway or in the garden, which functioned as a smoking area. There was no communal seating area or quiet space where residents could relax.

A dedicated activities nurse had been appointed since the focused inspection of July 2016 and was assigned to the Acute Unit. This nurse brought newspapers to the unit each morning at 9.30am and facilitated a news review. Acute Unit residents were risk-assessed for participation in recreational activities, such as going for a walk or joining a social activity in the day activities room in the Sub-Acute Unit. The activities nurse accompanied residents to activities in the Sub-Acute Unit on occasion. However, the activities nurse had no base or room in the Acute Unit and, therefore, no ongoing presence. At the time of inspection, residents were observed to be mainly lying in bed or pacing the unit. Two residents had been accompanied to the Sub-Acute Unit to engage in activities.

**The approved centre was not compliant with this regulation because it did not ensure, insofar as was practicable, access for residents to appropriate recreational activities.**

## Regulation 15: Individual Care Plan

**NON-COMPLIANT**

Risk Rating **HIGH**

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:** This regulation was inspected under evidence of implementation only.

**Evidence of Implementation:** Fifteen clinical files were inspected in relation to individual care plans (ICPs). The approved centre was non-compliant with this regulation because there was no ICP for two residents in the Acute Unit. Neither the assistant inspector nor the nurse in charge could locate ICPs in the clinical files of the two residents in question. One of these was a readmission and there was no evident ICP for the previous admission.

Twelve ICPs inspected and the following findings were made:

- Ten recorded that residents had been offered but declined copies of their ICPs.
- Twelve contained risk assessments.
- Four were developed by nursing and medical staff, not the entire multi-disciplinary team (MDT).
- Three had been developed by nursing and medical staff and one other discipline.
- Seven had not been signed by the resident.

**The approved centre was not compliant with this regulation for the following reasons:**

- a) Not all residents had an ICP.
- b) Not all ICPs were developed, reviewed, and updated by the MDT.

## Regulation 16: Therapeutic Services and Programmes

**NON-COMPLIANT**

Risk Rating **HIGH**

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

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

**INSPECTION FINDINGS:** This regulation was inspected under evidence of implementation only.

**Evidence of Implementation:** There were three activities nurses and a 0.6 whole-time-equivalent (WTE) occupational therapist assigned to the Department of Psychiatry (DOP) in Waterford University Hospital. One of the activities nurses was the designated Electro-Convulsive Therapy (ECT) nurse and was unavailable to the day activities programme whenever ECT was being administered.

There was a large room in the Sub-Acute Unit, which functioned as the day activities area. This room was well equipped with arts and crafts materials, recovery and psychoeducation group materials, a small kitchenette, books and newspapers, relaxation and yoga mats and comfortable chairs for groups.

The daily therapeutic group programme ran from 09.00 to 16.00. Each morning commenced with a relaxation CD or newspaper reading, and this was followed by an arts session provided by a member of the Waterford Healing Arts Trust (WHAT) or a volunteer who ran a jewellery making class twice a week. The afternoon sessions included yoga and holistic movement sessions provided by external staff, a skills group, and a weekend planning group. Individual care plan reviews were scheduled each afternoon. The timetable provided to inspectors generally featured one therapeutic option per time-slot and drew heavily on sessions provided by external agencies such as the WHAT and which were described as “nurse-led”. Otherwise, it was unclear how the activities nursing resource of approximately 2.6 WTE was utilised.

The Acute Unit had no communal seating area and the “occupational therapy room” was located at the rear of the unit and looked unused. The room was being used to store furniture and equipment at the time of inspection and was out of commission as a therapy room. It was accessed via a locked door and was adjacent to the Mental Health Tribunal room. Staff reported that use of this room depended on nursing staff availability to supervise residents, but staff were frequently unavailable due to the nursing care demands within the unit. Also, this room was not available when a tribunal was in process. At the time of the inspection, there was a two-seater couch and what staff described as a “therapeutic trolley” in the room. The trolley contained meagre equipment such as colouring books, a couple of novels, and a tiddlywinks board game. There were no suitable facilities for therapeutic services and programmes in the Acute Unit.

Since the focused inspection in July 2016, an Acute Unit therapeutic services and programmes committee had been set up. A second committee was also in place to develop a recovery ethos in each unit. These committees had been up and running for approximately five months and had produced written plans for a number of specific therapeutic groups and “Welcome” packs for residents. Despite these aspirational plans and the provision of one additional activities nurse post, little had actually materialised or been delivered. The provision of therapeutic services and programmes in the Acute Unit remained inadequate.

Discussions with the relevant staff indicated that no structured needs assessment had been undertaken to inform the development of appropriate group therapeutic programmes for the unit. Therapeutic programmes for this cohort of residents would need to meet diverse needs, from those who were acutely

unwell and distressed and to longer term residents who would typically require a recovery-oriented maintenance programme. The lack of any room or facility for therapeutic activities did not support an ongoing presence by activity staff, and activities staff reported what they perceived to be an absence of a therapeutic “culture” within the Acute Unit. No therapeutic programmes took place in the Acute Unit during the course of this inspection.

Staff said that community meetings were held in the Acute Unit and residents’ views were sought in relation to activities. There was no record maintained in relation to these meetings or of any actions or outcomes. The proposed group therapeutic programme for the Acute Unit drew heavily on existing resources available to the approved centre, such as the input by WHAT, rather than being informed by the assessed needs of residents.

The ICPs inspected outlined therapeutic goals and required interventions. Residents received input from social work, psychology, and occupational therapy (OT) on a limited individual basis. Inspection of the clinical files of residents in the Acute Unit did not indicate the provision of regular therapeutic groups or residents’ participation and engagement in therapeutic services and programmes, and the outcomes achieved. The activity nurse assigned to the Acute Unit brought one or two residents to activities in the Sub-Acute Unit and made an entry to this effect in the respective clinical files. At the time of the inspection, OT was being provided on an individual basis to three residents in the Acute Unit and assessment and intervention records were entered in the clinical files.

This regulation requires the registered proprietor to ensure that the therapeutic programmes and services provided are directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. This was not the case for residents in the Acute Unit, where neither facilities nor the provision of services provided residents with adequate opportunities to engage in physical, social and recreational, or daily living activities. Two residents had been in-patients for an extended length of time and were deprived of opportunities to maintain basic skills for living.

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

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

## Regulation 21: Privacy

**NON-COMPLIANT**

Risk Rating

**MODERATE**

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

**INSPECTION FINDINGS:** This regulation was inspected under evidence of implementation only.

**Evidence of Implementation:** Inspectors noted that residents were called by their preferred name and staff communicated with staff in a helpful and courteous manner. None of the noticeboards in the approved centre displayed residents' names or any confidential information. There was no public phone on the unit, but residents were facilitated to make or receive calls in private using the cordless phone from the nursing office.

All residents were observed to be dressed in either day or nightclothes, which were conducive to dignity and respect. Bathroom and shower rooms had locks for privacy. Windows that were overlooked were fitted with a protective film to ensure resident privacy.

At the time of the focused inspection, five residents in the Sub-Acute Unit were required to sleep in a day activities room while bedroom accommodation was being refurbished. Six beds, six hospital screens, and five bedside cupboards were in place. The screens were inadequate in terms of number and size to provide adequate privacy and dignity for residents assigned to these beds. In the Sub-Acute Unit, one two-bed room accommodated a single resident who required one-to-one nursing care. There was no privacy screen on the door panel or within the room, meaning that the resident's privacy was not adequately respected. All other beds in the approved centre were curtained or had privacy screens.

**The approved centre was not compliant with this regulation because residents' privacy and dignity were not appropriately respected all times.**

## Regulation 22: Premises

**NON-COMPLIANT**

Risk Rating **HIGH**

- (1) The registered proprietor shall ensure that:
  - (a) premises are clean and maintained in good structural and decorative condition;
  - (b) premises are adequately lit, heated and ventilated;
  - (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.
- (2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.
- (3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.
- (4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.
- (5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.
- (6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

**INSPECTION FINDINGS:** This regulation was inspected under evidence of implementation only.

**Evidence of Implementation:** Overall the premises, apart from the garden areas, were clean. The gardens were unsightly and strewn with cigarette butts. An enclosed courtyard area adjacent to the administrative offices and the entrance foyer of the approved centre contained an overflowing rubbish bin, which had evidently been in place and unattended for an extended period of time. This did not convey an adequate sense of regard for the dignity and respect of residents, their families, or visitors. The garden area in the Acute Unit was unattractive in appearance with sparse planting.

One of the lavatories in the Acute Unit contained an overflowing sanitary bin on the morning of the 24 January, and the inspection team immediately brought this to the attention of nursing staff. Despite several follow-up enquiries from inspectors, the bin was not attended to until the late afternoon of the following day. This demonstrated insufficient concern for the dignity of residents and for infection control.

Refurbishment works were under way at the time of inspection. The work included painting and decorating, replacing floor coverings, and remediating bathrooms, shower rooms, and lavatories. Overall, rooms were adequately ventilated, heated, and lit.

The accommodation and living facilities in the Sub-Acute Unit included a large dining/sitting room area, which opened onto a garden space, and a day activities area. There was a small room that could be used as a visitors' room. Unless otherwise risk assessed, residents in the Sub-Acute Unit could meet with visitors in the entrance hallway, where there were clusters of tables and chairs, or accompany visitors to the coffee shop in the main hospital concourse.

No such facilities were available in the Acute Unit. There was no visitors' room. There was no dining area and residents were obliged to eat their meals at their bedside tables. There was no communal seating area, and the only seating option was for residents to sit on their bedside chairs. The Acute Unit was cramped because there was no communal space for residents to spend their day. During the course of the

inspection, residents in the unit were observed to be either sitting at their bedside, pacing the corridor, or smoking in the garden area.

Two residents in the Acute Unit had been in-patients for between six months and three and a half years. They were not afforded with appropriate facilities to engage in physical, social and recreational, or daily living activities. Consequently, the environment could not be said to be appropriate to the physical and mental health and well-being of long-term residents. In the absence of opportunities or facilities to maintain basic living skills, the unit represented a deprived environment in this regard for those long-term residents. There were no comfortable chairs or quiet space in which residents could relax.

The approved centre had increased the bed numbers in the Acute Unit in September 2016 from 10 to 14, and this had compounded the problems and made the unit even more cramped. The registered proprietor provided the Mental Health Commission with plans for the building of additional sleeping and living accommodation in the Acute Unit, and the process was at tendering stage.

The design and layout of the approved centre did not provide good sight lines for nursing staff to observe residents. The location of the nursing offices in both the Acute and Sub-Acute Units did not allow for the observation of residents on the corridor areas. The Acute Unit had a side corridor providing access to a small outdoor space, which was not visible from the nursing office. The Sub-Acute Unit had a corridor en-route to the dining room and sitting room area, which could not be seen from the nursing office. In addition, there was a corridor to the day activities area and another corridor containing bedrooms and toilet facilities, which were not visible from the nursing office. The day activities corridor could be observed from an open nursing desk located outside the nursing office.

Both units required staff to be out and about to maintain ongoing resident observation and supervision. The door to the approved centre was locked on both days of the inspection owing to three individual residents having been risk assessed in relation to absconding. On the 24 March, three residents in the Acute Unit and two residents in the Sub-Acute Unit were being provided with one-to-one special nursing care to ensure their safety. These factors made the task of observing residents at all times more demanding.

An updated ligature anchor point audit had been completed on 16 January 2017. Remediation and refurbishment work had been completed in the Acute Unit. The audit report stated that there were eight ligature anchor points rated as low and three rated as medium in the Acute Unit. These were managed through individual risk assessment. The inspection team identified an additional ligature anchor point in the Acute Unit, which was examined the next day by an engineer. Management subsequently advised that the fitting would be rendered safe.

In the Sub-Acute Unit, refurbishment work was still under way at the time of the focused inspection and was scheduled to be completed by the 11 February 2017. Eighty-seven ligature anchor points were noted in the audit report, of which six were rated as high risk. These were managed through individual risk assessment and the assigning of bedrooms accordingly, and with rooms locked when not in use. Thirty-three ligature anchor points were rated as medium risk and 48 as low risk. Fourteen of these risks were in "high-traffic" areas, where residents had restricted access and were supervised throughout by staff.

One four-bed dormitory with en suite facilities contained ligature anchor points. Remediation work was under way in the Sub-Acute Unit to address these. Additional ligature anchor points in the Sub-Acute Unit had been identified by the approved centre and remediation work in relation to these had gone to tender.

**The approved centre was not compliant with this regulation for the following reasons:**

- a) The registered proprietor did not ensure that there was adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22(2).
- b) The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was 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, 22(3).

## Regulation 26: Staffing

**NON-COMPLIANT**

Risk Rating **HIGH**

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

**INSPECTION FINDINGS:** This regulation was inspected under evidence of implementation only.

**Evidence of Implementation:** There was an organisational chart detailing the management structure for the approved centre. The rota of nursing staff was made available to the inspection team and indicated sufficient members of staff on duty; the person on duty and in charge of the approved centre was a clinical nurse manager (CNM) 3.

The nursing staff numbers were adequate for the assessed resident needs and the size and layout of the approved centre. An assistant director of nursing (ADON) with specific responsibility for the approved centre had taken up the post in August 2016 and an additional CNM3 post had been put in place. The Director of Nursing advised that there was a core number of approximately 30 (WTE) nurses out of the 44.3 that were allocated to the DOP. The approved centre used agency and HSE overtime or bank nurses to maintain staffing numbers, and this contributed to staffing budget overspends.

Nursing allocations were managed by a CNM3 based at St. Otteran's Hospital campus. The allocations staff viewed the Acute and Sub-Acute Units as one and had assigned 12 staff to the day shift and 8 staff to the night shift. Within this allocation, the approved centre staff decided the complement and gender mix to be assigned to each unit.

On both days of inspection, there were two CNMs and nine registered psychiatric nurses (RPNs) assigned to the approved centre, four to five of whom were agency staff. Up to five residents were being provided with one-to-one special nursing care on both days. The protocol in the approved centre was for the first nursing one-to-one special to be drawn from the core nursing complement and additional specials to be contracted in, either from an agency or HSE bank staff. This should have translated into 15 nurses assigned on both days of the inspection, 12 nurses (including the first special) and three additional nurses as specials. In practice, there were 14 staff assigned at that time. The shortage of one nurse during the day meant that nursing staff assigned to day activities were required to cover meal breaks, leading to the cancellation of scheduled day activities for residents.

On the night of the 24 January 2017, there was a shared CNM3 and nine RPNs allocated to the approved centre, including one agency nurse. At that time, five residents were being provided with one-to-one nursing special care. Nursing staff said that nursing specials were commonly used in the approved centre for two main reasons:

- Any child admitted required a one-to-one nursing special.
- A number of residents in the Acute Unit had been assessed as requiring special one-to-one nursing.
- 

Inspection of the nursing day books indicated that, on a number of occasions in January 2017, up to six of the rostered nursing staff were agency staff. There were three agency nursing staff on duty on each day during the inspection.

Thirteen consultant-led teams admitted residents to the approved centre. While the Waterford and South Kilkenny consultant psychiatrists provided in-patient care for their residents, this was not the case for the Wexford residents. Here, the in-patient and out-patient components of care were generally provided by different consultant psychiatrists, which affected the continuity and cohesiveness of care.

Forty-five percent of consultant psychiatrist posts in the CHO 5 area were locum posts at the time of the inspection.

Nursing staff numbers were adequate to meet resident needs, but a number of factors combined to create demands on nursing staff, including:

- A high level of use of agency or bank staff.
- The migration of some nursing expertise to night duty.
- The level of usage of one-to-one nursing specials.
- The accommodation of multi-disciplinary team meeting schedules.
- The cancellation of scheduled activities for residents.
- The psychiatric acuity and number of residents in the cramped Acute Unit.
- Disruption caused by refurbishment works.

The Mental Health Commission stipulated four areas of mandatory training and required all clinical staff to be trained accordingly. The staff training in the approved centre fell well short of this requirement. There were 44.3 WTE nursing staff for the approved centre. Training records indicated that 12 nursing staff had fire safety training, 10 nursing staff were up to date with control and restraint or breakaway techniques, 10 nursing staff were up to date with Basic Life Support, and 16 nursing staff had completed Mental Health Act 2001 training. The training records for other disciplines were not included in this focused inspection.

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

**The approved centre was not compliant with this regulation because staff were not appropriately trained to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).**

| <i>Ward or Unit</i> | <i>Staff Grade</i>     | <i>Day</i>               | <i>Night</i> |
|---------------------|------------------------|--------------------------|--------------|
| Sub-Acute Unit      | CNM3 (shared)          | 1                        | 1            |
|                     | CNM2                   | 1                        | 0            |
|                     | RPN                    | 6                        | 4            |
|                     | Occupational Therapist | 0.6 (sessional – shared) | 0            |
|                     | Activities Nurse       | 3                        | 0            |
| <i>Ward or Unit</i> | <i>Staff Grade</i>     | <i>Day</i>               | <i>Night</i> |
| Acute Unit          | CNM3 (shared)          | 1                        | 1            |
|                     | CNM2                   | 1                        | 0            |
|                     | RPN                    | 6                        | 3            |
|                     | Occupational Therapist | 0.6 (sessional – shared) | 0            |

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

## Regulation 32: Risk Management Procedures

**COMPLIANT**

Quality Rating

Satisfactory

- (1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.
- (2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
- (a) The identification and assessment of risks throughout the approved centre;
  - (b) The precautions in place to control the risks identified;
  - (c) The precautions in place to control the following specified risks:
    - (i) resident absent without leave,
    - (ii) suicide and self harm,
    - (iii) assault,
    - (iv) accidental injury to residents or staff;
  - (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
  - (e) Arrangements for responding to emergencies;
  - (f) Arrangements for the protection of children and vulnerable adults from abuse.
- (3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

### INSPECTION FINDINGS

**Processes:** The approved centre had a June 2016 CHO 5 service-wide policy on risk management. It identified the risk manager and described the process for the identification and management of risks within the approved centre and for rating these risks. The policy addressed the risks associated with resident absence without leave, suicide and self-harm, assault, and injury to residents or staff. It did not address capacity risks relating to the number of residents in the approved centre. The policy made reference to the Mental Health Commission (MHC) being notified of incidents in accordance with relevant MHC codes of practice but did not identify the person responsible for completing six-monthly incident summary reports.

**Training and Education:** Senior staff reported that clinical staff were trained in individual risk management processes. There was no evidence that management staff were trained in organisational risk management. Staff were trained in incident reporting and documentation. Relevant staff had read and understood the policy and relevant staff interviewed were able to articulate the processes for risk management.

**Monitoring:** The risk register was audited at least quarterly to determine compliance with the approved centre's risk management policy. The audit recorded actions taken to address risks against the time frames identified on the register. Incidents were recorded using the National Incident Management System (NIMS). Incidents were risk-rated, and they were reviewed by the risk manager.

**Evidence of Implementation:** The approved centre had a designated risk manager, who was known to staff. Responsibilities were allocated at management level to ensure the effective implementation of risk management. Clinical, health and safety, and corporate risks were identified, assessed, treated or mitigated, reported, monitored, and documented in the risk register. Where applicable, risks were progressed to the CHO 5 risk register.

Fifteen clinical files were inspected in relation to risk, and each contained a risk assessment and management plan completed at the time of admission and reviewed by the multi-disciplinary team as clinically indicated. The risk management plans for three residents in the Sub-Acute Unit included the door to the approved centre being locked and this was reviewed and documented on a daily basis.

The Acute Unit was locked. On days one and two of the inspection, four and five residents, respectively, were being risk managed using one-to-one nursing specials. Nursing staff interviewed in both units were able to clearly articulate the risk management issues and plans for individual residents and were confident in their ability as a team to manage and provide appropriate care to the residents. They were observed to interact in an open, relaxed, and respectful manner with residents and were out and about on the units throughout the inspection.

The requirements for protecting children and vulnerable adults in the approved centre were appropriate and implemented as required. The approved centre was included in the Waterford University Hospital's Emergency Plan.

There were site-specific risk analysis and evaluation forms completed in December 2016. The specific risks and hazard controls identified included privacy and the provision of temporary screens. The forms indicated that two additional nursing staff were assigned during the course of refurbishment work. The forms also included the scheduled and future plan for ligature remediation works.

Residents were clinically risk-assessed at the time of admission and on an ongoing basis thereafter. Sleeping accommodation was assigned according to residents' individual risk assessments. A clinical nurse manager (CNM) 3 had been assigned as a project manager to oversee resident safety during the refurbishment works. The CNM3 provided an update to the health and safety committee, which met quarterly. At the time of the inspection, there were no health and safety representatives for the approved centre. The health and safety policy was a CHO 5 service-wide policy and was implemented in the approved centre.

Two residents of the approved centre had passed away between 2016 and 2017. Both deaths were recorded as suspected suicides. Two non-fatal incidents had been reported in 2017 where residents were found with ligatures around their necks and were attended to by staff. These unanticipated, adverse or sentinel events took place in the Sub-Acute Unit. All incidents were reported and recorded via NIMS and were reviewed and followed-up in local clinical and management governance fora. All serious reportable events were systematically reviewed, with reports provided to the CHO5 Quality and Safety Executive Committee. All deaths and serious reportable events were reported to the MHC within the required time frames. Six-monthly summary reports of all incidents were forwarded to the MHC.

**The approved centre was compliant with this regulation. The quality assessment was rated 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.**