

Mental Health Commission
Approved Centre Inspection Report
(Mental Health Act 2001)



APPROVED CENTRE NAME	Selskar House, Farnogue Residential Care Unit
IDENTIFICATION NUMBER	AC0092
APPROVED CENTRE TYPE	Psychiatry of Later Life
REGISTERED PROPRIETOR	Health Service Executive
REGISTERED PROPRIETOR NOMINEE	Mr David Heffernan
MOST RECENT REGISTRATION DATE	02 May 2016
NUMBER OF RESIDENTS REGISTERED FOR	20
INSPECTION TYPE	Unannounced
INSPECTION DATE	18, 19, 20 October 2016
PREVIOUS INSPECTION DATE	14, 15, 16 October 2015
CONDITIONS ATTACHED	No
LEAD INSPECTOR	Ms Mary Connellan
INSPECTION TEAM	Ms Marianne Griffiths
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCN009711

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1.0 Mental Health Commission 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, and
- 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 shall 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 shall 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 shall be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgment 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. The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

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

The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

Selskar House was located behind Wexford General Hospital on the Old Hospital Road. It opened in 2013 and occupied the lower ground floor of Farnogue House. The approved centre was purpose built and accommodated 20 residents in single rooms, all with en-suite facilities. At the time of inspection, the approved centre was operating at full capacity. None of the residents were detained. The upper floor was occupied by another centre that provided care for the elderly (Abbeygale Ward), which shared some visiting and group room amenities, an oratory and a hairdressing salon with Selskar House.

The approved centre was square in shape, with an internal garden and an external garden to the rear. There was a kitchen servery and dining room and a large television and lounge facility. There were two nursing stations and a clinical room. There was no dedicated recreational room on the ground floor, but a suitable recreational space had been identified in the corridor at an unused nursing station. The space was appropriate to the needs of residents, encouraging them to participate in regular recreational activities that were provided. There was a calm and organised ambiance within the service, and each resident was cared for in a respectful manner. Family members visited at different times and were included in the care of residents. They were also observed engaging in recreational activities, which was representative of the inclusive atmosphere throughout the approved centre on the days of the inspection.

2.2 Conditions to Registration

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

2.3 Governance

The approved centre was governed by the Wexford/Waterford Mental Health Service. It was part of Community Healthcare Organisation 5 (CHO5), which included Wexford/Waterford and South Tipperary, Carlow/Kilkenny Mental Health Services. The Wexford and Waterford services shared the same governance structures and, since January 2016, had adopted the same policies and procedures where practicable and appropriate to the resident profile.

The minutes of the Selskar House business meetings and the wider management team meetings were presented to the inspection team. These documented discussions in relation to the development of clinical and non-clinical posts, capital investment within the CHO and actions to be taken to further develop written policies and procedures. Quality and Safety Executive Committee meetings for the Wexford/Waterford Mental Health Service were held monthly.

2.4 Inspection Scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against. The inspection was undertaken on-site in the approved centre on the following dates and times:

18 October 2016 at 09:30 to 18 October 2016 at 17:00

19 October 2016 at 09:00 to 19 October 2016 at 17:00

20 October 2016 at 09:00 to 20 October 2016 at 16:00

2.5 Non-Compliant areas from 2015 inspection

The previous inspection of the approved centre on 14th, 15th and 16th October 2015 identified the following areas that were not compliant:

Regulation/Rule/Act/Code	Inspection Findings 2016
Regulation 16: Therapeutic Services and Programmes	Compliant
Regulation 21: Privacy	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Compliant
Regulation 25: Use of Closed Circuit Television	Not Applicable
Regulation 26: Staffing	Non-Compliant
Regulation 28: Register of Residents	Compliant
Regulation 29: Operating Policies and Procedures	Compliant
Regulation 32: Risk Management Procedures	Compliant
Rules Governing the Use of Mechanical Means of Bodily Restraint	Compliant

2.6 Corrective and Preventative Action Plan

The approved centre had Corrective and Preventative Actions (CAPAs) from the 2015 inspection:

- As part of the CAPA for Regulation 16 Therapeutic Activities, the approved centre had planned to recruit and appoint an Occupational Therapist (OT); this post had been nationally approved, however the OT was not yet in position.
- Seating assessment referrals had been made for any residents who required them.
- Behavioural needs assessments had not been completed for residents by the senior psychologist in the psychiatry of later life team.
- In terms of privacy, the notice displayed in the dining hall no longer contained residents' names and all residents' files were stored securely.
- The recording function of the closed circuit television (CCTV) cameras had been disabled, and a policy had been developed on the function of CCTV.
- In order to address the CAPA for Regulation 23 the Ordering Prescribing Storing and Administration of Medicines, Medical Council Registration Numbers (MCRNs) were included on all prescriptions, and documented prescriptions to crush medicines were included in medication records.
- In terms of Regulation 26, Staffing, registration of nursing staff was not recorded by the assistant director of nursing, as required by the CAPA. A policy on staffing had been developed.
- The Register of Residents was amended to include all of the information specified in Schedule 1 of the Regulations.
- A health and safety policy had been developed in order to adhere to the CAPA on Risk Management
- Similarly, risk register training had been provided to all staff of Selskar House. Trend analysis had been conducted for risk at the approved centre. All risks were considered by the Quality and Safety Executive Committee and a monthly ward management meeting was held at which risks that had arisen were discussed.
- A new form was introduced to be completed by staff prescribing the use of mechanical restraint for residents. The mechanical restraint policy was reviewed to reflect the use of mechanical restraint in terms of the enduring risk of self-harm to residents.

2.7 Non-Compliant Areas on this Inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 26: Staffing	Moderate
Regulation 27: Maintenance of Records	Low
Code of Practice on the Use Physical Restraint in Approved Centres	Low
Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Low

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.

2.8 Areas of Compliance Rated Excellent on this Inspection

Regulation/Rule/Act/Code
Regulation 10: Religion

2.9 Areas Not Applicable

The following areas were not applicable as the rule, regulation, code of practice or Part 4 of the Mental Health Act 2001 were not relevant to the approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 17: Children's Education
Regulation 25: Use of Closed Circuit Television
Regulation 30: Mental Health Tribunals
Rules Governing the Use of Seclusion
Rules Governing the Use of Electro-Convulsive Therapy
Part 4 of the Mental Health Act 2001, Consent to Treatment
Code of Practice Relating to the Admission of Children under the Mental health Act 2001
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients

2.10 Areas of Good Practice Identified on this Inspection

- The approved centre participated in the Healthcare-Associated Infections in Long-Term Care Facilities (HALT) study to reduce antimicrobial use and associated infections.
- A Quality Safety Executive Committee had been set up since the previous inspection.
- The internal garden was in the process of being landscaped and redeveloped.

2.11 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.

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

There were no patients on approved leave at the time of inspection.

2.13 Resident Interviews

Residents of the approved centre were invited to meet with the inspection team. Throughout the course of the inspection the inspectors spoke with residents on an informal basis. Two residents expressed satisfaction with the care provided. Family members were complimentary about the service and the care received by residents.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	1	19	0	20
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	1	19	0	20
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	1	19	0	20
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

A feedback meeting was held prior to the conclusion of the inspection. This provided an opportunity for the inspectors to give preliminary feedback and clarify any outstanding issues. Those in attendance included the following:

- Manager of Waterford/Wexford Mental Health Services
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Clinical Nurse Manager 3
- Senior Clinical Psychologist
- Clinical Nurse Manager 2 x 2
- Consultant Psychiatry of Later Life
- Clinical Placement Coordinator

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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

Inspection Findings

Processes: The approved centre had a written policy on the identification of residents. It included the roles and responsibilities in relation to the identification of residents and the process to be applied to residents with a similar or the same name.

The policy did not include the required use of two identifiers prior to the administration of medications, therapies or medical investigations.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on the identification of residents. Staff could articulate the process for identifying residents, as set out in the policy.

Monitoring: No audit had been completed in respect of the identification of residents. No analysis had been completed to identify opportunities to improve the resident identification process.

Evidence of Implementation: A minimum of two resident identifiers, both of which were appropriate to the residents' individual needs, were detailed within the residents' clinical files. These identifiers were person-specific and appropriate to the residents' communication abilities. Two identifiers were used when administering medications. There was a sticker alert system in place in the case of similar and same name residents.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.5 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 policy for food and nutrition. It documented the roles and responsibilities for food and nutrition and the process for managing residents' food and nutrition. The policy specified the procedure for assessing the dietary and nutritional needs of residents. The policy did not include the process for monitoring food and water intake.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy. Staff could articulate the processes for food and nutrition, as set out in the policy.

Monitoring: Nutritional team meetings with the catering manager, dietician and nutritionist had taken place in the facility that supplied the food to the approved centre – St. John's Community Hospital, Enniscorthy. This group had completed analysis that identified opportunities to improve the processes relating to food and nutrition.

Evidence of Implementation: Food was prepared and cooked off-site in St. John's Community Hospital kitchen and delivered to the approved centre in hot trolleys. Approved centre menus were reviewed and approved by a catering manager, dietician and nutritionist. Residents had a variety of wholesome and nutritious food choices, and the options were documented in the approved centre menus. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour and appearance. Hot and cold drinks were offered to residents on a regular basis, and a safe, fresh source of drinking water was available.

An evidence-based nutrition assessment was not routinely available to all residents. Referrals to the dietetic service in Wexford General Hospital were made by the general practitioner. Weight charts were implemented, monitored and acted upon for residents where appropriate. Residents and their representatives were educated about the residents' diets. Nutritional and dietary needs were assessed by a dietician where necessary and incorporated into the Individual Care Plan. A speech and language therapist attended the approved centre. Intake and output charts were maintained for residents where appropriate.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.6 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 policy in place in relation to food safety. The policy detailed the roles and responsibilities in relation to food safety as well as the relevant food safety legislation requirements. It included the processes for the preparation, handling, storage, distribution and disposal of food.

The policy did not specify the process for managing catering and food safety equipment.

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

Catering management were trained in HACCP, however these staff worked off-site. Staff in the approved centre did not have up to date training in food safety and hygiene.

Monitoring: No food safety audits had been completed within the approved centre. Food temperatures were recorded in line with food safety recommendations. No analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering staff, and personal protective equipment was worn. There was suitable and sufficient catering equipment available in the approved centre, and the kitchen was modern and clean. There were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Hygiene was maintained to support food safety requirements, and catering areas, including 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 for their specific needs.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.7 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 policy in relation to residents' clothing. It outlined the required use of day and night clothing as well as the process for recording the wearing of nightclothes during the day.

The policy did not specify the responsibility of the approved centre to provide clothing in consideration of the residents' preferences, dignity, bodily integrity and religious and cultural practices.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on residents' clothing. Staff could articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The approved centre did not monitor the availability of an emergency supply of clothing. No record had been kept of residents wearing nightclothes during the day.

Evidence of Implementation: The approved centre supported residents to keep and use their personal clothing. A household staff was employed three days' per week to wash and manage residents' clothing. All clothing observed over the course of the inspection was clean and appropriate to residents' needs. Residents were provided with emergency personal clothing that was appropriate to their preferences, dignity, bodily integrity and religious and cultural practices. All residents were wearing day clothes during the inspection, and residents had an adequate supply of individualised clothing.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.8 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 relating to residents' personal property and possessions. The policy included the roles and responsibilities of the approved centre to support residents to manage their personal property and possessions. The process for recording, securing and managing residents' personal property and possessions, including money, was documented in the policy. The following were not covered by the policy:

- The process for giving residents access to and control over their personal property and possessions.
- The process for communicating with the resident regarding their entitlement to bring personal property into the approved centre.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on residents' property and possessions. Staff could articulate the process for residents' personal property and possessions, as set out in the policy.

Monitoring: Residents' personal property logs were maintained and monitored. No analysis had been completed to identify opportunities to improve the process for residents' personal property and possessions.

Evidence of Implementation: Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of residents' monies, valuables and personal property, as necessary. The approved centre maintained signed property checklists detailing each residents' personal property and possessions. Access to and use of resident monies was overseen by two members of staff. Where any money belonging to the resident was handled by staff, signed records of the issuing of the money were retained. Residents were supported to manage their property and possessions unless otherwise indicated in their individual care plan. Records relating to a residents' personal property and possessions were kept separately from the residents' individual care plan.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: The approved centre had a policy for the provision of recreational activities. It outlined the roles and responsibilities around providing recreational activities, the process for determining residents' likes and dislikes in relation to activities and the process for developing recreational activities programmes. The policy detailed the methods for communicating with residents about recreational activities and individual activities programmes and supporting resident involvement in providing input into the recreational activities available.

The policy did not include details of the following:

- The process for risk assessing residents prior to their participation in recreational activities.
- The facilities available for recreational activities, including the identification of suitable locations within and outside the approved centre.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on recreational activities. Staff could articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record of the occurrence of planned recreational activities, including a record of resident uptake, was maintained in the approved centre. No analysis had been completed to identify opportunities to improve the process for recreational activities.

Evidence of Implementation: The approved centre organised recreational activities that were appropriate to the resident group profile. The activities took place on weekdays but not at weekends. The approved centre did not have a vehicle to facilitate outings. There were two staff on a community work placement under the 'Tús' initiative. These staff provided recreational activities to the residents. Individual risk assessments had been completed for residents in relation to the selection of appropriate activities. Recreational activity programmes had been developed, implemented and maintained with resident involvement. Opportunities had been provided for indoor and outdoor exercise, and communal areas were available for activities. Documented records of attendance were retained for recreational activities in group records and in the resident's clinical file.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.10 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 policy for the facilitation of religious practice by residents. It detailed the roles and responsibilities in relation to supporting residents' religious practice. The policy outlined the procedure for identifying residents' religious beliefs, facilitating residents in the practice of their religion and respecting religious beliefs during the provision of services, care and treatment.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on the facilitation of religious practice. Staff could articulate the process 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 had been reviewed to ensure that it reflected the identified needs of the residents.

Evidence of Implementation: The residents' rights to practice religion had been facilitated within the approved centre. Residents had access to multi-faith chaplains if required. During the inspection, all residents were Roman Catholic. The approved centre had access to an on-site oratory, where mass was celebrated every Sunday. The local priest attended the approved centre throughout the week. Care and services provided within the approved centre were respectful of the residents' religious beliefs and values. Any specific religious requirement relating to the provision of services, care and treatment was clearly documented. Residents had been facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The approved centre was quality assessed as excellent because it met all the criteria of the *Judgement Support Framework*.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.11 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 operational policy on visits. It specified the roles and responsibilities in relation to visiting the approved centre and its residents. There was a process in place for restricting visitors based on a resident's request, an identified risk to the resident or an identified health and safety risk. The arrangements and appropriate facilities for children visiting a resident were included in the policy.

The policy did not include a process for required visitor identification.

Training and Education: Staff had not signed a policy log indicating that they had read and understood the policy on visits. Staff could articulate the process for visits, as set out in the policy.

Monitoring: The implementation of the policy on visits was reviewed to ensure that it reflected the identified needs of residents. No analysis was completed to identify opportunities to improve the visiting process.

Evidence of Implementation: Visiting times were publicly displayed in the approved centre. The times were appropriate and reasonable. Two visitors' rooms were available and suitable for visiting families with children. Children visiting were to be accompanied at all times to ensure their safety. Visitors were welcome in the approved centre at all times but were encouraged to respect protected mealtimes. The approved centre took all reasonable steps to ensure the safety of residents and visitors. Similarly, the freedom of a resident to receive visits and the privacy of a resident during visits was respected. There were no restrictions of residents receiving visitors at the time of inspection.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.12 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. The policy included roles and responsibilities for resident communication processes and outlined the communication services available to the resident in terms of mail, telephone and internet. The policy outlined the process for assessing residents' communication needs.

The policy did not detail individual risk assessment requirements in relation to resident communication activities, nor did it include the circumstances in which resident communication could be examined by a senior member of staff. Access to an interpreter was not covered in the policy.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on communication. Staff could articulate the process for resident communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions were not monitored in the approved centre. No documented analysis had been completed to identify opportunities to improve the communication processes.

Evidence of Implementation: Individual risk assessments were completed for residents as deemed appropriate. Staff considered it unlikely that external communication would represent a risk to residents and no resident had restrictions on their communication during the inspection. Residents had access to mail, e-mail, telephone and personal mobile phones within the approved centre.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.13 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 searching of a resident. The policy detailed the management and application of searches of a resident, their belongings and the environment. It specified 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, the roles and responsibilities in relation to the implementation of resident searches and the application of individual risk assessment in relation to resident searches were all included.

The policy did not include details of the following:

- The process for communicating the approved centre's policy on searches.
- The process for informing the resident being searched about what was happening and why.
- The considerations in relation to residents' dignity and privacy during a search.
- The requirements to record searches, including the reason for the search.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy. Staff could articulate the processes relating to searches, as set out in the policy.

No searches had been conducted in the approved centre since the previous inspection. The regulation was assessed in relation to processes and training and education and not quality assessed.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.14 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. The policy specified the roles and responsibilities in relation to care of the dying as well as the identification and implementation of the residents' physical, emotional, social, and psychological and pain management needs for end of life care. The requirements for advance directives and Do Not Attempt Resuscitation orders were included. The privacy, propriety and dignity requirements were documented in the policy, which included provision for the involvement and accommodation of resident representatives, family and next of kin during end of life care. The processes for managing a resident's sudden death and the responsibility for reporting a death to the appropriate external bodies, including the Mental Health Commission (MHC), were specified in the policy.

The policy did not include the process for ensuring that the approved centre was informed of the death of a resident who had been transferred elsewhere.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy. Staff could articulate the processes for end of life care, as set out in the policy.

Monitoring: End of life care provided to the residents was not systematically reviewed to ensure compliance with Section 2 of Regulation 14. No analysis had been completed to identify opportunities to improve the processes for care of the dying.

Evidence of Implementation: An end of life care plan had been in place for residents who were dying. The plan documented residents' physical, emotional, social, psychological and spiritual needs. Religious and cultural practices had been respected, and the privacy and dignity of residents were protected in terms of the provision of single bedrooms.

Representatives, family and next of kin had been involved, supported and accommodated during the end of life care process. Pain management was prioritised and managed in conjunction with the local palliative care team, as appropriate.

There had been no sudden death of a resident in the approved centre since the 2015 inspection. All deaths of residents had been notified to the MHC within the required 48-hour time frame.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.15 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 policy for Individual Care Plans (ICPs). This detailed the roles and responsibilities relating to the development of ICPs and the comprehensive resident assessments that are performed on admission and on an ongoing basis. The policy included the requirement for ICP reviews and updates as well as the required resident involvement in the individual care planning process.

The policy did not include details of the following:

- The required content of the documentation making up the ICP.
- The time frames for assessment planning, implementation and evaluation of ICPs.
- The process for facilitating resident access to their ICPs.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on individual care planning. Staff could articulate the processes relating to individual care planning, as set out in the policy. Twenty-two multi-disciplinary staff had attended specific ICP training.

Monitoring: ICPs had not been audited on a quarterly basis to assess compliance with the regulation. The most recent ICP audit was completed in January 2016. Analysis had been documented that identified opportunities to improve the ICP processes.

Evidence of Implementation: All 20 residents had an ICP, which had been developed by the Multi-Disciplinary Team (MDT) following a comprehensive assessment at admission. The assessment included medical, psychiatric and psycho-social histories; details of current medications; physical health assessments; and detailed risk assessments. The initial assessments did not address resident communication abilities. All 20 ICPs were examined as part of the inspection process. Resident input into their ICPs was not documented in seven cases, and family input into the ICPs varied depending on the relationship between the resident and family members.

The ICPs identified appropriate goals for the resident as well as the care and treatment required to meet these goals. They also identified the resources needed to provide the care and treatment identified, including nursing, medical, social work and psychology. A key worker system was in place within the approved centre. The ICPs included a risk management plan for each resident.

All of the ICPs had been reviewed by the MDT and included nursing, medical and social work input. Two ICPs also contained input from a psychologist. All ICPs had been reviewed within a six-month time frame. In three cases, there was no documentation to indicate that

residents were offered a copy of their ICP or no explanation of the rationale behind not offering the ICP to them. In all cases, the ICP was a composite set of documents.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.16 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 policy in relation to therapeutic services and programmes. It specified the roles and responsibilities around therapeutic services and the process in place for the delivery of therapeutic services by external providers in external locations. The resource requirements, the recording requirements and the process for the review and evaluation of therapeutic services were each documented in the policy.

The policy did not provide details of processes relating to the use of facilities for therapeutic services and programmes.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on therapeutic services and programmes. Staff could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: No ongoing monitoring of therapeutic services and programmes was evident in the approved centre. There was no documented analysis completed to identify opportunities to improve the processes for therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents as documented in Individual Care Plans. Therapeutic services and programmes were evidence-based, and adequate resources and facilities were available for their provision. Where a resident required a therapeutic service or programme that was not provided directly by the approved centre, arrangements had been made to ensure that these were delivered by an approved, qualified health professional in an appropriate location. Examples of these services included chiropody and speech and language therapy. No list of therapeutic services and programmes provided within the approved centre was available to residents. The approved centre had access to three therapy rooms for individual and group therapies. A record was maintained of residents' participation in, engagement with and outcomes achieved in therapeutic services. Programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psycho-social functioning.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.17 Regulation 17: Children's Education

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

Inspection Findings

As the approved centre did not admit children, this regulation was not applicable.

3.18 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 operational policy in relation to the transfer of residents. This included the roles and responsibilities for the resident transfer process. The planning and management of resident transfers, the criteria for transfers and the process for making a decision to transfer a resident from the approved centre were covered in the policy. Resident assessment requirements prior to the transfer from the approved centre and the resident involvement in the transfer process were also specified.

The policy did not include processes for the following:

- Managing residents' medications during the transfer.
- Ensuring residents' privacy and confidentiality during the transfer.
- Managing resident property during the transfer.
- Ensuring the safety of the resident and staff during the transfer.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on resident transfer. Staff could articulate the process for the transfer of residents, as set out in the policy.

Monitoring: The approved centre did not maintain a log of transfers, and there was no documented record of a review of each resident transfer to ensure that all relevant information was provided to the receiving facility. No analysis had been completed to identify opportunities to improve the transfer process.

Evidence of Implementation: The file of a resident who had been transferred out of the approved centre was examined as part of the inspection process. The file included communication records with the receiving facility and documentation of the reasons for transfer, the communication of the resident's care and treatment plan and the accompaniment of the resident being transferred.

An assessment of the resident was completed prior to transfer. A member of staff accompanied the resident on transfer and this staff member transported all relevant information pertaining to the transfer. A letter of referral, including a list of current medication and a resident transfer form, were completed. However, copies of these documents were not retained in the clinical file.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

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

Inspection Findings

Processes: The approved centre had a written operational policy in relation to responding to medical emergencies. It outlined the roles and responsibilities around responding to medical emergencies and the management of emergency response equipment.

The policy did not include details of the following:

- The process for the management of, response to and documentation of a medical emergency.
- The staff training requirements in relation to Basic Life Support.

The approved centre had a separate policy for general health. It detailed the roles and responsibilities in relation to the provision of general health services to residents and the ongoing assessments of residents' general health needs. The approved centre's process for ensuring resident access to national screening programmes was included in the policy. Details of the following were not included in the general health policy:

- The protocol for residents' access to a registered medical practitioner.
- The resource requirements for general health services.
- The process for incorporating residents' general health needs into Individual Care Plans (ICPs).
- The process for supporting healthy lifestyle choices.
- The procedure for protecting residents' privacy and dignity during general health assessments.
- The referral process for residents' general health needs.
- The documentation requirements in relation to general health.

Training and Education: Staff had signed a policy log indicating that they had read the policy on medical emergencies. They had not signed to indicate that they had read the policy on general health. Staff could articulate the processes for the provision of general health services and for responding to medical emergencies, as set out in the policies.

Monitoring: A system of monitoring was in place to ensure that residents' six-monthly general health reviews took place. There had been no monitoring to ensure resident uptake of national screening programmes or analysis to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had a resuscitation trolley that was kept in the clinical room. It was checked on a monthly basis, which was in contravention of the approved centre's own policy which stated that the emergency trolley would be checked weekly. A resident general practitioner attended the approved centre daily to assess residents' general health needs. Residents received appropriate general health care interventions in line with their ICPs. Residents' general health needs were monitored and assessed no less than every six months, and records were available demonstrating that the health checks had been completed.

Adequate arrangements were in place to give residents access to general health services and to refer them to other health services as required. Residents had access to national screening programmes, as appropriate. Opportunities for residents to pursue healthy lifestyle choices had been made available by the approved centre, insofar as was practicable.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.20 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 operational policy for the provision of information to residents. The roles and responsibilities in relation to the provision of information and the type of the information provided to residents at admission were detailed. The methods for providing information to residents with specific communication needs and the available interpreter services were also specified in the policy. The process in relation to advocacy arrangements was included.

The policy did not include details of the following:

- The process for identifying residents' preferred ways of giving and receiving information.
- The process for managing the provision of information to residents and their families.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy. Staff could articulate the processes for providing information to residents, as set out in the policy.

Monitoring: A nursing metrics tool had been used to monitor the provision of information to residents. No analysis had been completed to identify opportunities to improve the process for providing information to the residents.

Evidence of Implementation: Information was provided to residents at admission, including the approved centre's information booklet. It contained details of the housekeeping arrangements, complaints procedure, visiting times and residents' rights. Residents were provided with details of their Multi-disciplinary Teams (MDT) as well as written and verbal information relating to diagnosis. Diagnosis-specific leaflets were provided, and information on the likely adverse effects of treatment was offered to residents.

The information in the documents provided by the approved centre was evidence-based and appropriately reviewed and approved prior to use. Residents had access to interpretation services, as required.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: The approved centre had a policy on privacy. It specified the roles and responsibilities in relation to ensuring residents' privacy and dignity as well as the methods for identifying and fulfilling residents' privacy and dignity expectations. The requirements of the approved centre's layout and furnishings in supporting privacy and dignity were documented in the policy.

The process applied when resident privacy and dignity were not respected by staff was not included in the policy.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on privacy. Staff could articulate the process for ensuring resident privacy, as set out in the policy.

Monitoring: The approved centre had not conducted an annual review to check that the policy was implemented and that the premises and facilities were conducive to resident privacy. No analysis had been completed to identify opportunities to improve the processes relating to residents' privacy and dignity.

Evidence of Implementation: The approved centre offered single-bedroom accommodation to all residents. All bathrooms, showers and toilet doors had locks with an override function. All observation panels on doors had blinds or opaque glass. Noticeboards did not contain names of residents, and a phone handset was available to resident to facilitate private calls.

Residents were called by their preferred names, and the manner in which staff communicated with them was respectful of privacy and dignity. Staff appearance and dress was appropriate at all times, and staff were discrete when discussing resident conditions or treatment needs. Staff also sought permission before entering residents' rooms. During the inspection, all residents wore clothes that preserved their privacy and dignity.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.22 Regulation 22: Premises

(1) *The registered proprietor shall ensure that:*

(a) *premises are clean and maintained in good structural and decorative condition;*

(b) *premises are adequately lit, heated and ventilated;*

(c) *a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.*

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

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

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

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

(6) *This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.*

Inspection Findings

Processes: The approved centre had a policy in relation to the premises. It specified the responsibilities of all staff in the approved centre with regard to the premises. The legislative requirements to which the approved centre must conform, the premises maintenance programme and the utility controls and requirements were all covered in the policy.

Details of the following were not included in the policy:

- The cleaning programme.
- The infection control programme.
- The processes for identifying hazards and ligature points.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on premises. Staff could articulate the processes relating to premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene and infection control audit and a ligature audit. Documented analysis had been completed to identify opportunities to improve the premises.

Evidence of Implementation: Residents had access to personal space and appropriately sized common rooms. The approved centre provided accommodation for each resident that was furnished and equipped to meet their needs and support resident independence and comfort. Assistive devices were available to residents, as required.

There was a suitable heating system in place, and rooms were ventilated. Lighting was adaptable, and sufficient spaces were provided for residents to move about, both indoors and outdoors. There were locks on the bedroom doors, and these had an override function. Ligature points were minimised. The approved centre was in a good state of repair, and there was a programme of general maintenance, decorative maintenance and cleaning in place. The approved centre was clean, hygienic and free from offensive odours, and current national infection control guidelines were followed. Where faults or problems were identified with the premises, they were communicated through the appropriate maintenance reporting process.

Sufficient access to toilets and showers were available to residents in the approved centre. These were accessible, clearly marked and located near the dining areas. The approved centre had a designated sluice room, cleaning room and laundry room, and three therapy rooms were available. A programme of routine maintenance and renewal of the fabric and decoration of the premises was developed and records of such improvements were maintained by the approved centre. The approved centre environment had been developed and maintained with due regard to the specific needs of the residents and the safety and well-being of residents, staff and visitors.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.23 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.*

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

Inspection Findings

Processes: The approved centre had a written operational policy relating to the ordering, prescribing, storing and administration of medicines. The policy included details of the roles and responsibilities in relation to medication. It documented the processes for self-administering medication, withholding medication and reconciling medication. The process for administering controlled drugs, including checks and record requirements, was covered in the policy, as was the process for managing medication errors, including external reporting requirements.

The policy did not include details of the following:

- The legislative requirements and professional codes of practice.
- The process for crushing medication.
- The process for medication management at admission, transfer and discharge.
- The process for reviewing residents' medication.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on medication. Staff could articulate the processes for ordering, prescribing, storing and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All staff received training on the importance of reporting medication incidents.

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

Evidence of Implementation: An MPAR was maintained for each resident. It contained appropriate resident identifiers, the medication names written in full, dedicated space for routine, details of once-off and as-required medication and dosage information. The administration route for the medication was documented in all cases. A clear record of the date of initiation and discontinuation for each medication was in place. The Medical Council Registration Number (MCRN) and signature of every prescribing medical practitioner were included in the MPARs. In ten cases, the allergy section of the MPAR had not been completed.

Medication was reviewed on a six-weekly basis. In the event that medication was altered, the relevant prescription was rewritten. All medicines were administered by a registered nurse and in accordance with the directions of the prescriber. Good hand hygiene and cross-

infection control techniques were implemented during the dispensing of medicines. Occasions when medication was withheld from a resident or when a resident refused medication were documented. Controlled drugs were checked by two staff members against the delivery form and details were recorded. Directions to crush medications were only accepted from the resident's medical practitioner.

Medication arriving from the pharmacist was verified against the order by a nurse to ensure that it was correct. Medication was stored in the appropriate environment. Where refrigerated storage was necessary, a temperature log was maintained. Medication storage areas were free from damp and mould, and they were included in the cleaning schedules. Food and drink was not stored in areas used for the storage of medication.

Medication was stored securely in a locked storage unit, which was kept in a locked room. Scheduled controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. A system of stock rotation had been implemented to avoid the accumulation of old stock, and medications that were no longer required were returned to the pharmacy for disposal. The approved centre did not conduct an inventory of medication on a monthly basis.

The approved centre was compliant with this regulation. The quality assessment was satisfactory but not excellent because the approved centre did not meet all the criteria of the *Judgement Support Framework* under processes and evidence of implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.24 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 place outlining processes and procedures relating to health and safety. The policy outlined the roles and responsibilities of staff in ensuring the health and safety of residents, staff and visitors. The health and safety risk management process and the fire management plan were specified, as were relevant infection control measures, including the safe handling and disposal of health-related risk waste, hand washing and responses to sharp or needle-stick injuries. The policy also included information on the availability of staff vaccinations, first aid requirements and fall prevention initiatives.

The policy did not include information on the following:

- The specific roles allocated to the registered proprietor for the achievement of health and safety legislative requirements.
- Safety representative roles.
- The contents of the safety statement.
- The process for raising awareness of infection control for staff and residents.
- The process for managing spillages.
- Infection control measures relating to specific infection types.
- Requirements relating to monitoring of health and safety processes.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on health and safety. Staff could articulate the processes relating to health and safety, as set out in the policy.

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

Evidence of Implementation: The written policies and procedures accurately reflected the operational practices in the approved centre.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.25 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 anytime on request.

Inspection Findings

As closed circuit television (CCTV) was used solely for security purposes and not for resident observation, this regulation was not applicable.

3.26 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 operational policy in relation to staffing. It detailed the processes for recruitment, selection, appointment and vetting of staff as well as the roles and responsibilities in relation to staffing. The policy contained the staff job description requirements, the staff rota details and the means for its communication to staff. The orientation and induction training for new staff and the ongoing staff training requirements were also covered in the policy.

The policy did not include information on the following:

- The organisational structure of the approved centre.
- The evaluation of training programmes.
- The staff performance and evaluation requirements.
- The processes relating to the employment of agency staff.

Training and Education: Relevant staff had not signed policy log indicating that they had read and understood the staffing policies. Relevant staff could articulate the processes relating to staffing, as set out in the policies.

Monitoring: The implementation and effectiveness of the staff training plan had been reviewed on an annual basis. The number and skills mix of staff had been reviewed against the levels recorded in the approved centre's registration. Business meeting minutes indicated that analysis had been completed to identify opportunities to improve staffing processes.

Evidence of Implementation: There was an organisational chart that identified the leadership and management structure and the lines of authority for the approved centre. There was a planned staff rota. The number and skills mix of staffing was sufficient to meet resident needs, and staff were recruited and selected in accordance with the HSE procedures. Staff had appropriate qualifications, skills, knowledge and experience to do the job. An appropriately qualified staff member was on duty and in charge at all times.

There was a written staffing plan for the approved centre, which addressed the skill mix, competencies and number of staff. The staffing plan took into consideration the assessed needs of the resident group. Where agency staff were used, there was a comprehensive contract between the approved centre and the agency. Agency staff were not employed in the approved centre at the time of inspection. Annual staff training plans were completed, and they identified necessary training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed for staff.

A training record for nursing staff only was made available to the inspection team. Staff received training in accordance with the assessed needs of the resident group profile, and this included manual handling and infection control and prevention. Opportunities were made available to staff for further education. In-service training was completed by appropriately trained individuals.

Not all clinical staff were trained in fire safety, Basic Life Support (BLS), therapeutic management of aggression and violence (TMAV) and the Mental Health Act (2001). There had been no training in the protection of vulnerable adults or in end of life care. Risk management training had taken place for staff, and one member of staff was trained in the Children First guidelines.

The approved centre was non-compliant with this regulation because not all staff had up-to-date training in fire safety, BLS, TMAV and the Mental Health Act (2001), as per Regulation 26 (4).

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

Ward or Unit	Staff Grade	Day	Night	
Unit A	CNM 2	1	0	
	RPN	3	2	
	HCA	2	1	
	Occupational Therapist	0		
	Social Worker	0.50 WTE		
	Psychologist	0.25 WTE		
<i>Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)</i>				
	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
	Low	Moderate	High	Critical
		X		

3.27 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.*

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

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

Inspection Findings

Processes: The approved centre had a written operational policy in relation to the maintenance of records. It outlined staff responsibilities for the creating, accessing, retaining and destroying records. The process for ensuring privacy and confidentiality of residents' records and content was included in the policy, as were the relevant legislative requirements relating to record maintenance and the implementation of the Data Protection Acts. The policy also covered the processes for making entries in a clinical file, including retrospective entries, and general safety and security measures in relation to records. The process for the retention of inspection reports relating to food safety, health and safety and fire inspections was also specified in the policy.

The policy did not include details of the following:

- The requirements relating to resident record creation and content.
- The individuals authorised to access and make entries in resident records.
- The process for facilitating resident access to records.
- The process for the destruction of records.
- The requirements relating to record review.

Training and Education: Staff had not signed a policy log indicating that they had read and understood the policy on the maintenance of records. Staff could articulate the process for creating, accessing, retaining and destroying records. Staff had not been trained in best-practice record keeping.

Monitoring: Residents' records had not been audited to ensure their completeness, accuracy and ease of retrieval. No analysis had been completed to identify opportunities to improve the records maintenance process.

Evidence of Implementation: All records had been maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records were kept up to date and in good order. There was a record for each resident, and records were physically stored together. They were reflective of the residents' current status and accessed using a unique identifier. Residents' records were compiled and maintained in a logical sequence.

Only authorised staff made entries in residents' records, which were secured throughout the approved centre. Resident records were maintained appropriately and written legibly, in black ink. Entries were factual, consistent and accurate. Each included the date and time using the 24-hour clock as well as a signature. The approved centre maintained a record of all signatures used.

Resident names and dates of birth was detailed on all documentation. Records were retained and destroyed in accordance with legislative requirements and the approved centre policy. The approved centre retained documentation of food safety, health and safety and fire inspection.

The approved centre was non-compliant with this regulation because the written policy did not include provision for resident record creation and content, resident access to their records or destruction of resident records (27 (2)).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
Low	Moderate	High	Critical	
X				

3.28 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

The approved centre had a Register of Residents, which contained all of the information as required by Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.29 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 policy for the development, management and review of operating policies and procedures. The roles and responsibilities were outlined, as was the process for the approval and dissemination of new and updated policies. The processes for reviewing and updating operating policies at least every three years, taking obsolete documents out of circulation and retaining previous versions of the policies were included. The process for staff training on operating policies, including the requirements for training following the release of a new or updated operating policy, was also covered in the policy. The standardised operating policy layout used in the approved centre was described, the process for collaboration between clinical and managerial staff to provide relevant information as a basis for policy development was detailed.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy. Staff were able to articulate the process for developing and reviewing operational policies.

Monitoring: A documented audit of policies had not been undertaken to determine compliance with policy review time frames. However, a policy group had recently been established to identify opportunities to improve the processes around 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 conjunction with relevant stakeholders. They incorporated relevant legislation and clinical guidelines, were appropriately reviewed and had been communicated to all relevant staff. The operating policies and procedures required under the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but could not be accessed by staff. The format of policies and procedures was standardised and contained the title as well as details of the document owner, the scope of the policy and the date from which the policy was to be implemented. Where generic policies were used, the approved centre had a written statement to this effect.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.30 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

As there were no detained patients in the approved centre at the time of inspection, this regulation was not applicable.

3.31 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 on the complaints management process. It outlined the roles and responsibilities associated with the management of complaints, including reference to a nominated person responsible for dealing with complaints. The policy documented the process for managing complaints, including raising, handling and investigating. There was a process for communicating the complaints policy to residents and their representatives. The methods for making a complaint and the process for escalating complaints that cannot be addressed by the nominated person were detailed in the policy.

The confidentiality requirements in relation to complaints and the time frames for responding to complaints were not documented in the policy. The written policy did, however, reference the generic HSE complaints management policy *Your Service Your Say*, which contained the required timeframes for responding to complaints.

The policy did not include specific information on the following processes, which were referenced in the HSE complaints management policy:

- The documentation of complaints, including the maintenance of a complaints log by the nominated person.
- The protocol for communicating with the complainant during the complaint process.
- The appeals process available to the complainant who was dissatisfied with the outcome of an investigation.

Training and Education: Relevant staff in the approved centre had not received training on the complaints management process. Staff had not signed to indicate that they had read

the complaints policy. Staff could articulate the processes for making, handling and investigating complaints, as set out in the policy.

Monitoring: No audits of the complaints log had been completed by the approved centre, and complaints data had not been analysed to identify opportunities to improve the complaints process.

Evidence of Implementation: A nominated person was responsible for dealing with complaints to the approved centre. A consistent and standardised approach was implemented for the management of all complaints, and the approved centre adhered to the protocols of the HSE policy *Your Service Your Say*. Advocates were available to residents or representatives as required. Each resident was made aware of the complaints process as soon as practicable after admission. The approved centre's process for the management of complaints was well publicised and accessible to residents. It was documented in the information booklet. All complaints were investigated promptly, and a system for addressing minor complaints locally was provided. The approved centre maintained a complaints book.

The complaints process was managed by personnel based in the campus of St. Senan's Hospital, Enniscorthy. Where minor complaints could not be dealt with locally, they were escalated to the nominated complaints officer. All escalated complaints were dealt with by the nominated person and recorded in the complaints log. All complaints and the results of any investigations into matters complained about were fully recorded and these records were maintained distinct from the residents' individual care plan.

Details of complaints, as well as subsequent investigations and outcomes, were fully recorded, and time frames were provided for the expected resolution of complaints. Where time frames had not been achieved, there was communication with the complainant. The complainant's satisfaction with the investigation findings was documented. All information obtained through the complaints management system and associated investigation were treated in a confidential manner.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.32 Regulation 32: Risk Management Procedures

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

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

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

Inspection Findings

Processes: The approved centre had a written operational policy in relation to risk management. The policy outlined the roles and responsibilities in relation to risk management, including reference to the person responsible for risk management and the responsibilities of the registered proprietor. The process for completing six-monthly incident reports was documented, but the person responsible for this process was not indicated. The defined quality and safety oversight structure and the process of identification, assessment reporting and risk monitoring throughout the approved centre were documented in the policy. However, neither organisational risks nor capacity risks were included. Structural risks, including ligature points, were covered in the policy. Precautions were in place to control the specified risks of: resident absence without leave, suicide and self-harm, assault and accidental injury. The process for maintaining and reviewing the risk register and the record-keeping requirements were documented in the policy.

The risk management policy documented the process for managing incidents involving residents, including the method for risk rating incidents and investigating, documenting and reviewing incidents that occurred in the approved centre. The policy covered the processes for notifying the Mental Health Commission about incidents involving residents, for protecting children and vulnerable adults and for responding to specific emergencies.

Training and Education: Training in the identification, assessment and management of risk had been completed by five management staff from the approved centre. There was no documented training in terms of health and safety risk management, individual risk management, organisational risk management or incident reporting and documentation. Staff had signed a policy log indicating that they had read and understood the risk

management policy, and staff could articulate the risk management processes, as set out in the policy.

Monitoring: All incidents in the approved centre were recorded and risk rated. The risk register had not been audited on a quarterly basis to determine compliance with the risk management policy. No analysis of incident reports had been completed to identify opportunities for improvement of the process.

Evidence of Implementation: Responsibilities were allocated at management level and throughout the approved centre to ensure effective implementation of risk management processes. The person with responsibility for risk was identified and known by all staff. Clinical and health and safety risks were identified, assessed, treated, reported and monitored. Structural risks, including ligature points, were minimised and effectively mitigated. Individual risk assessments were completed at admission, transfer and discharge. Multi-Disciplinary Teams (MDTs) were involved in the development, implementation and review of the individual risk processes. Corporate risks were identified, assessed, treated, reported and monitored by the approved centre. The requirements for the protection of vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded in a standardised format, and all clinical incidents were reviewed by the MDT. The person with responsibility for risk management reviewed incidents to identify possible trends. Incident report forms were available and used throughout the approved centre, and a six-monthly summary report of all incidents was provided to the Mental Health Commission. There was an emergency plan in place that specified responses by the approved centre staff.

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

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.33 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 had insurance cover provided to the HSE by the State Claims Agency. It covered public liability, employer's liability, clinical indemnity and property.

The approved centre was compliant with this regulation.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.34 Regulation 34: Certificate of Registration

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

There was an up-to-date certificate of registration prominently displayed in the approved centre.

The approved centre was compliant with this regulation

	Compliant	Non-Compliant
Compliance with Regulation	X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

Section 59

(1) *“A programme of electro-convulsive therapy shall not be administered to a patient unless either –*

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or

(b) where the patient is unable to give such consent –

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

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

Inspection Findings

As the approved centre did not provide Electro-Convulsive Therapy, this rule was not applicable.

4.2 Section 69: The Use of Seclusion

Mental Health Act 2001

Bodily restraint and seclusion

Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient".

Inspection Findings

As the approved centre did not use seclusion, this rule was not applicable.

4.3 Section 69: The Use of Mechanical Restraint

Mental Health Act 2001

Bodily restraint and seclusion

Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient".

Inspection Findings

Processes: The approved centre had a written operational policy on the use of mechanical restraint, as per Part 5 of the Rules.

Evidence of Implementation: Six episodes of mechanical restraint were reviewed over the course of the inspection. In each case, the use of mechanical restraint was ordered by a registered medical professional. The files examined indicated that the residents in question were at risk of harm in terms of falls and that less restrictive alternatives were implemented without success. The type of mechanical restraint used had been described to include the situations where it was to be applied. The authorised duration of the restraint, the duration of the order for mechanical restraint and the review date for mechanical restraint had been documented in all cases.

The approved centre was compliant with the rule on mechanical restraint.

	Compliant	Non-Compliant
Compliance with Rule	X	

5.1 Part 4: Consent to Treatment

56.- *In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where –*

- (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and*
- (b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.*

57. - *(1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.*

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – *Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-*

- (a) the patient gives his or her consent in writing to the continued administration of that medicine, or*
- (b) where the patient is unable to give such consent –*
 - i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and*
 - ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,*

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

61. – *Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –*

- (a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and*
- (b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,*

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

Inspection Findings

As there were no detained patients in the approved centre at the time of inspection, Part 4 Consent to Treatment was not applicable.

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: The approved centre had a written policy outlining the processes in relation to the use of physical restraint. The policy had been reviewed on an annual basis and included the requirement on the provision of information to the resident and identifying who may initiate and carry out physical restraint.

There was no policy on staff training for the use of physical restraint. Consequently, there was no documented process identifying appropriately qualified individuals to deliver training, no reference to the mandatory nature of training, and no caution against using physical restraint to ameliorate staff shortages.

Training and Education: Staff had signed a policy log indicating that they had read and understood the policy on physical restraint. A record of attendance at training on Safe Work place Practices and Elder Care (Or equivalent) had been maintained.

The approved centre had not used physical restraint since the previous inspection.

The approved centre was non-compliant with this code of practice because there was no policy in relation to the training of staff in the use physical restraint 10.1 (a) (b) (c) (d) (e).

	Compliant		Non-Compliant	
Compliance with Code of Practice			X	
Risk Rating				
Low	Moderate	High	Critical	
X				

6.2 Admission of Children

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

Inspection Findings

As the approved centre did not admit children, this code of practice was not applicable.

6.3 Notification of Deaths and Incident Reporting

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

Inspection Findings

Processes: The approved centre had a risk management policy that detailed the process in place for the notification of deaths and incidents. The policy identified a risk manager and the roles and responsibilities of staff members in relation to the reporting of deaths and incidents. It detailed the roles and responsibilities for the completion of death notification forms and submission of a report to the Mental Health Commission (MHC). The process for the completion of six-monthly incident summary reports was included in the policy.

Training and Education: Staff were aware of the policy on the notification of deaths and incidents and this was documented.

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

Evidence of Implementation: The approved centre was compliant with Regulation 32: Risk Management. There was an incident reporting system in place and a standardised incident report form had been used. A six-monthly summary of all incidents had been provided to the MHC. The Standardised Incident Report Form was made available to the inspection team.

The approved centre was compliant with this code of practice.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

6.4 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

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

Inspection Findings

Processes: The approved centre had policies and protocols in place for working with people with an intellectual disability. They reflected person-centred treatment planning and the presumption of capacity. The policy reflected least restrictive interventions and detailed the roles and responsibilities of staff in terms of care and treatment of people with an intellectual disability. There was a separate policy on the management of problem behaviours.

The approved centre did not have a policy for training of staff working with people with an intellectual disability. Consequently, details of induction training for new staff, areas to be addressed in training and staff who should receive training were not documented. There was no written process that detailed the frequency of training, identification of appropriately qualified people to deliver training or evaluation of training programmes. There was no protocol for ensuring appropriate and relevant communication with external agencies for people with intellectual disabilities.

Training and Education: There was no record of training that supported the principles and guidance in the Code of Practice. Similarly, staff of the approved centre had not completed training programmes in the areas of person-centred approaches to care, relevant human rights principles or preventative and responsive strategies to problem behaviours.

Monitoring: The policy on the care and treatment of people with intellectual disabilities had been updated on a three-yearly basis as required. The approved centre did not use physical restraint or seclusion, and restrictive practices were minimised.

Evidence of Implementation: The files of two residents with an intellectual disability were examined as part of the inspection. Each resident had an Individual Care Plan (ICP) detailing the levels of support and treatment required, assessed needs and resources and supports available. The ICPs did not document consideration of the environment for each resident. A comprehensive assessment of the resident had taken place on admission and included medical, psychiatric and psycho-social history, mental state examination and risk assessment. Performance capacities and difficulties were not documented for residents with an intellectual disability. Key workers had been identified and their names were documented in the resident ICPs. The residents' preferred ways of receiving and giving information was not documented in either file examined, nor was the residents' understanding of information. Inter-agency collaboration (to ensure a smooth transition from one service to another) was documented in the file of one resident. There was no evidence of inter-agency collaboration in the second file examined.

The involvement of family, advocate and carer was encouraged for both residents, and a least restrictive environment was established to meet the residents' needs. Opportunities for engagement in meaningful activities had been provided to residents. There was no record of a functional capacity assessment for either resident.

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

- a) There was no policy for the training of staff in working with people with intellectual disabilities 6.2.
- b) Inter-agency collaboration was not documented in the file of one resident 7.1
- c) There was no communication protocol for ensuring appropriate and relevant communication with external agencies for people with intellectual disabilities, 7.2.
- d) Education and training on person-centred approaches to care, relevant human rights principles and preventative and responsive strategies to problem behaviours had not been provided 6.2.
- e) Residents' preferred ways of receiving and giving information had not been established 9.1.
- f) There was no evidence that information was appropriate and accessible 9.2.
- g) Residents' understanding of information had not been documented 9.6.
- h) No functional capacity assessment had been conducted with residents who had an intellectual disability 12.2.

	Compliant	Non-Compliant	
Compliance with Rule		X	
Risk Rating			
Low	Moderate	High	Critical
	X		

6.5 The 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

As the approved centre did not provide Electro-Convulsive Therapy, this code of practice was not applicable.

6.6 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: Admission: The approved centre adhered to the Waterford/Wexford Mental Health Services' admissions policy. This policy stated that all admissions were arranged through the relevant psychiatry of old age teams. There were written protocols for individuals who self-presented and for urgent referrals. The policy documented the protocol for timely communication with primary care and community mental health teams.

Transfer: The approved centre had a policy on transfer, which detailed the process for arranging transfers and the provisions made for an emergency transfer. The transfer policy did not specify the process for maintaining resident and staff safety during a transfer.

Discharge: The approved centre adhered to the Waterford/Wexford Mental Health Services discharge policy. It detailed roles and responsibilities for staff in terms of providing follow-up care. The policy also included follow-up care for residents. The policy included the procedures for managing discharge against medical advice.

The discharge policy did not include the following:

- The procedure for discharging involuntary patients.
- The process for medication requirements on discharge.
- The provision of relapse prevention strategies.
- The process for crisis management plans.
- The process around follow-up management and missed appointments.
- The protocol for the discharge of people with an intellectual disability.

Training and Education: Staff had signed a policy log indicating that they had read the policies on admission, transfer and discharge

Monitoring: There was no audit on the implementation of or adherence to the admission and discharge processes.

Evidence of Implementation:

The approved centre was compliant with Regulation 7: Clothing.

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

The approved centre was compliant with Regulation 20: Provision of Information.

The approved centre was compliant with Regulation 32: Risk Management, as required by the Code of Practice.

The approved centre was non-compliant with Regulation 27: Maintenance of Records

Admission: The approved centre had a key worker system in place. All Multi-disciplinary Team (MDT) records were kept in one file, and in all cases admission was because of a mental disorder or illness. The decision to admit was made by a Registered Medical Practitioner (RMP). An admission assessment was completed for each new admission and all assessments were retained in resident clinical files. These assessments included a history of the presenting problem, previous psychiatric history and medical history. There was evidence of family involvement in the admission process.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The file of a resident who had been transferred from the approved centre was examined. The transfer took place for medical reasons, and the decision to transfer was made by a RMP and was agreed with the receiving facility. Assessments, including risk assessments, were conducted prior to the transfer, and the resident's family were involved in the transfer process.

Discharge: The file of a recently discharged resident was examined as part of the inspection process. The decision to discharge the resident was made by a RMP. The file contained a discharge plan and included documented communication with the primary care team and the early warning signs of relapse. A discharge meeting had taken place in advance of the resident discharge and included resident representatives. A comprehensive assessment was completed prior to discharge and included a mental state exam, a risk assessment and an assessment of the resident's psychiatric and psychological needs. Appropriate MDT input was documented in the discharge plan, which was coordinated by the key worker. Efforts were made to link in with the Community Mental Health Team (CMHT), and comprehensive discharge summary had been sent within 14 days. The summary included a record of resident prognosis, diagnosis and medication. The resident's family was involved in the discharge.

The approved centre was non-compliant with the Code of Practice on Admission, Transfer and Discharge for the following reasons:

- a) The approved centre was non-compliant with Regulation 27, Maintenance of Records
- b) The transfer policy did not specify the process for maintaining resident and staff safety during the transfer process, 4.13.
- c) The discharge policy did not document the procedure for discharging involuntary patients, 4.2.
- d) The discharge policy did not include a process for the supply of medication to be provided on discharge, as appropriate, 4.10.
- e) The discharge policy did not reference relapse prevention strategies and crisis management plans, 4.14.
- f) The discharge policy did not detail the level of follow-up contact residents should have or a way of managing missed appointments, 4.14.
- g) The discharge policy did not indicate the procedure for discharging a person with an intellectual disability, 4.16.

	Compliant	Non-Compliant	
Compliance with Code of Practice		X	
Risk Rating			
Low	Moderate	High	Critical
X			

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: Selskar House

Date submitted: 15th March 2017

For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	Specific <i>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</i>	Measurable <i>Define the method of monitoring the implementation of the action(s)</i>	Achievable/ Realistic <i>State the feasibility of the action(s) (i.e. barriers to implementation)</i>	Time-bound <i>Define time-frame for implementation of the action(s)</i>
1. Not all staff had up-to-date training in fire safety, BLS, TMAV and the Mental Health Act (2001), as per Regulation 26 (4).	<p>A schedule of training has been co-ordinated through each Head of Discipline in order to ensure compliance with mandatory training requirements.</p> <ul style="list-style-type: none"> • Fire safety training has been arranged for all staff in the coming two weeks. • There is 1 on site BLS trainer and they will facilitate onsite training for all staff in the approved centre • TMAV training has been provided for 6 staff and a further 6 staff have been sent for training this week. • All staff have been informed that MHA 01 training is to be conducted on line through e-learning. Department heads will monitor compliance on a ongoing basis 	<p>Each Head of Discipline will conduct a bi-annual audit to review training uptake and establish action plans to ensure staff have up to date training.</p> <p>All attendance at training will be recorded and updated on training database</p>	<p>This is a realistic and achievable action</p>	<p>June 2017</p>

	Post-holder(s): Head of Disciplines			
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Regulation 27: Maintenance of Records (inspection report reference 3.27)				
Area(s) of non-compliance	Specific	Measurable	Achievable/ Realistic	Time-bound
	<i>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</i>	<i>Define the method of monitoring the implementation of the action(s)</i>	<i>State the feasibility of the action(s) (i.e. barriers to implementation)</i>	<i>Define time-frame for implementation of the action(s)</i>
2. The written policy did not include provision for resident record creation and content or the loss or destruction of resident records 27 (2).	The CHO5 Policy Committee have developed a draft policy on the maintenance of records which includes provision for resident record creation and content or the loss or destruction of resident records. It will be presented to Q.S.E.C. May 2017. Post-holder(s): Service Manager	The method of monitoring the implementation of this action will be through the established review schedule of the CHO5 Policy Committee.	This is an achievable and realistic action.	June 2017

Code of Practice: The Use of Physical Restraint (inspection report reference 6.1)				
Area(s) of non-compliance	Specific <i>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</i>	Measurable <i>Define the method of monitoring the implementation of the action(s)</i>	Achievable/ Realistic <i>State the feasibility of the action(s) (i.e. barriers to implementation)</i>	Time-bound <i>Define time-frame for implementation of the action(s)</i>
3. There was no policy in relation to the training of staff in the use physical restraint 10.1 (a) (b) (c) (d) (e).	<p>The CHO5 Policy Committee have reviewed the current Physical Restraint policy with the aim of identifying the necessary training for relevant staff.</p> <p>Post-holder(s): Service Manager/Chair of Policy Committee</p>	<p>The method of monitoring the implementation of this action will be through the established review schedule of the CHO5 Policy Committee.</p>	<p>This is a realistic and achievable action</p>	<p>June 2017</p>

Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities (inspection report reference 6.4)

Area(s) of non-compliance	Specific	Measurable	Achievable/ Realistic	Time-bound
	<i>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</i>	<i>Define the method of monitoring the implementation of the action(s)</i>	<i>State the feasibility of the action(s) (i.e. barriers to implementation)</i>	<i>Define time-frame for implementation of the action(s)</i>
4. There was no policy for the training of staff in working with people with intellectual disabilities 6.2.	<p>The CHO5 Policy Committee is currently devising a policy in relation to people with an Intellectual disability in mental health services. This policy will identify the necessary training required for relevant staff.</p> <p>Post-holder(s): Service Manager/Chair of Policy Committee</p>	The method of monitoring the implementation of this action will be through the established review schedule of the CHO5 Policy Committee.	This is a realistic and achievable action	June 2017
5. Inter-agency collaboration was not documented in the file of one resident 7.1	Evidence of interagency collaboration will be provided. A request for assessment by specialist intellectual disability consultant will be made. Collaboration in planning the resident with an intellectual disability's care will be sought from a specialist outside service provider.	The method of monitoring the implementation of this action will be through healthcare record audit to confirm proposed actions.	This is a realistic and achievable action	June 2017

	Post-holder(s): Dr. Niall Gormley			
6. There was no communication protocol for ensuring appropriate and relevant communication with external agencies for people with intellectual disabilities, 7.2.	<p>The CHO5 Policy Committee have been contacted and is currently devising a protocol for ensuring appropriate and relevant communication with external agencies for people with intellectual disabilities.</p> <p>Post-holder(s): Chair of CHO5 Policy Group/Service Manager</p>	The method of monitoring the implementation of this action will be through the established review schedule of the CHO5 Policy Committee.	This is a realistic and achievable action	November 2017
7. Education and training on person-centred approaches to care, relevant human rights principles and preventative and responsive strategies to problem behaviours had not been provided 6.2.	<p>Education and training will be provided by staff whom have recently attained Level 9 qualification in <i>Meeting the Challenges of Challenging Behaviour</i>.</p> <p>Post-holder(s):Area Director of Nursing</p>	Individualised Care Plan Reviewing will document the Behaviour Support programmes and service user engagement. A training record will be available on site for review.	This is a realistic and achievable action	August 2017

<p>8. Residents' preferred ways of receiving and giving information had not been established 9.1.</p>	<p>Preventative action(s): Residents' with an intellectual disability will be supported in the receiving and giving of information through the implementation of Communication Passports, in line with the Code of Practice Guidelines. This will be the property of the resident and the usage of same will be documented in the resident's ICP.</p> <p>Post-holder(s): Clinical Placement Coordinator/ Keyworker</p>	<p>Measurable by the on going process of both ICP and MDT review and evaluation.</p>	<p>This is a realistic and achievable action</p>	<p>June 2017</p>
<p>9. There was no evidence that information was appropriate and accessible 9.2.</p>	<p>Corrective Action: Residents with an Intellectual Disability will be provided with information in a way that is accessible and congruent with their preferred means of communication as outlined in their communication passport. Post-holder(s):MDT/ Keyworkers</p>	<p>Measurable by the on going process of both ICP and MDT review and evaluation.</p>	<p>This is a realistic and achievable action</p>	<p>June 2017</p>
<p>10. Residents' understanding of information had not been documented 9.6.</p>	<p>Residents' understanding of information will be documented in initial admission assessments, individual care plans and the</p>	<p>Measurable by the on going process of both ICP and MDT review and evaluation.</p>	<p>This is a realistic and achievable action</p>	<p>June 2017</p>

	<p>communication passport of the person with an intellectual disability.</p> <p>Post-holder(s):MDT/ Keyworkers</p>			
<p>11. No functional capacity assessment had been conducted with residents who had an intellectual disability 12.2.</p>	<p>Corrective action(s): A functional capacity assessment will be sought from a specialist consultant in intellectual disability in collaboration with the responsible consultant psychiatrist at Selskar House.</p> <p>Post-holder(s): Consultant Psychiatrist Dr Niall Gormley.</p>	<p>Measurable by the on going process of both ICP and MDT review and evaluation.</p>	<p>This is a realistic and achievable action</p>	<p>August 2017</p>

Code of Practice: Admission, Transfer and Discharge (inspection report reference 6.6)				
Area(s) of non-compliance	Specific	Measurable	Achievable/ Realistic	Time-bound
	<i>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</i>	<i>Define the method of monitoring the implementation of the action(s)</i>	<i>State the feasibility of the action(s) (i.e. barriers to implementation)</i>	<i>Define time-frame for implementation of the action(s)</i>
12. The transfer policy did not specify the process for maintaining resident and staff safety during the transfer process, 4.13.	All files pertaining to transfers in to and from the Approved Centre during 2016 have been reviewed to ensure that safety was maintained during the transfer process. Post-holder(s): Consultant Psychiatrist/Clinical Nurse Manager	Review of Healthcare Records which reflected documentation of Transfer process.	Achieved	March 2017
	The Service Manager will write to the chairperson of the CHO5 Policy Committee to request that the Transfer Policy is expedited for review to reflect the process for maintaining resident and staff safety during the transfer process. Post-holder(s): Service Manager/ Chair CHO 5 Policy Group	The implementation of this action will be monitored through the review schedule for policy updates by the chairperson of the CHO5 Policy Committee.	This action is achievable and realistic.	November 2017
13. The discharge policy did not include:	The Service Manager will write to the chairperson of the CHO5 Policy Committee to request that the Transfer Policy is expedited	The implementation of this action will be monitored through the review schedule for	This action is achievable and realistic.	November 2017

<ul style="list-style-type: none"> • the procedure for discharging involuntary patients, 4.2; • a process for the supply of medication to be provided on discharge, as appropriate, 4.10; • relapse prevention strategies and crisis management plans, 4.14; • the level of follow-up contact residents should have or a way of managing missed appointments, 4.14; and • the procedure for discharging a person with an intellectual disability, 4.16. 	<p>for review to reflect the criteria for 4.2/4.10/4.14/4.16 Post-holder(s): Service Manager/ Chair CHO 5 Policy Committee</p>	<p>policy updates by the chairperson of the CHO5 Policy Committee.</p>		