## Mental Health Commission

### Approved Centre Inspection Report

(Mental Health Act 2001)

<table>
<thead>
<tr>
<th><strong>APPROVED CENTRE NAME:</strong></th>
<th>St Anne’s Unit, Sacred Heart Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IDENTIFICATION NUMBER:</strong></td>
<td>AC0072</td>
</tr>
<tr>
<td><strong>APPROVED CENTRE TYPE:</strong></td>
<td>Psychiatry Of Old Age</td>
</tr>
<tr>
<td><strong>REGISTERED PROPRIETOR:</strong></td>
<td>HSE</td>
</tr>
<tr>
<td><strong>REGISTERED PROPRIETOR NOMINEE:</strong></td>
<td>Rose Malone</td>
</tr>
<tr>
<td><strong>MOST RECENT REGISTRATION DATE:</strong></td>
<td>19 September 2014</td>
</tr>
<tr>
<td><strong>NUMBER OF RESIDENTS REGISTERED FOR:</strong></td>
<td>12</td>
</tr>
<tr>
<td><strong>INSPECTION TYPE:</strong></td>
<td>Unannounced</td>
</tr>
<tr>
<td><strong>INSPECTION DATE:</strong></td>
<td>15, 16 October 2015</td>
</tr>
<tr>
<td><strong>PREVIOUS INSPECTION DATE:</strong></td>
<td>04 September 2014</td>
</tr>
<tr>
<td><strong>CONDITIONS ATTACHED:</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>LEAD INSPECTOR:</strong></td>
<td>Mr Damien Lanigan</td>
</tr>
<tr>
<td><strong>INSPECTION TEAM:</strong></td>
<td>Ms Orla O’Neill</td>
</tr>
<tr>
<td><strong>THE INSPECTOR OF MENTAL HEALTH SERVICES:</strong></td>
<td>Dr Susan Finnerty MCN009711 (Acting)</td>
</tr>
</tbody>
</table>
1.0 Mental Health Commission Inspection Process

The principal functions of the 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 under this Act.

The Mental Health Commission strives to ensure its principal legislative functions are achieved through the registration 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). 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 Mental Health Act (2001), 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 Section 4 of the Mental Health Act 2001 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 individual regulation, or rule, shall also be risk assessed.

The Approved Centre is required to act on all aspects identified as non-compliant or with a high / critical risk rating. Demonstration of immediate corrective rectifications, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and time-bound. All actions must have identified timeframes and responsibilities.

A copy of the draft report was forwarded to the service and comments and review on the report were invited from the Registered Proprietor. These comments were reviewed by the lead inspector and incorporated into the report, where relevant.

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health 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

The approved centre was located on the grounds of and attached to the Sacred Heart Hospital in Castlebar. The approved centre was one ward that was locked and situated on ground level. It was a single storey building dating from the 1970s. It was a 12 bedded residential unit which catered for people with challenging behaviour associated with dementia. In this unit, assessment, interim care, continuing care and limited respite care is provided for people over 65 years of age. On the days of inspection there were 6 residents, 5 male and 1 female resident. All residents were voluntary.

2.2 Governance

There was an organisational chart and clear governance structures and processes in place. Minutes of the Risk Management Committee were provided to the inspection team and evidenced regular senior management meeting and appropriate governance structures.

2.3 Inspection scope

This was an unannounced annual inspection that was conducted on the:
- 15 October 2015 from 0900h to 1800h
- 16 October 2015 from 0830h to 1700h

The regulations, rules and codes of practice were inspected against; Consent, Admission of Children, Children’s Education, CCTV, Seclusion and Electro Convulsive Therapy were not applicable to the Approved Centre at the time of inspection.

2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on the 19 September 2014 identified it was not fully compliant in two areas. The compliance rating achieved in the 2015 inspection is presented below.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Inspection Findings 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Compliant Excellent</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Compliant Excellent</td>
</tr>
</tbody>
</table>

2.5 Conditions to Registration

There were no conditions attached to the registration of this approved centre at the time of inspection.
2.6 Non-compliant areas on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>Low</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

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

2.7 Areas of compliance rated Excellent on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
</tr>
<tr>
<td>Regulation 24: Health and Safety</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedure</td>
</tr>
<tr>
<td>Regulation 33: Insurance</td>
</tr>
<tr>
<td>Regulation 34: Certificate of Registration</td>
</tr>
<tr>
<td>Code of Practice, The Use of Mechanical Restraint</td>
</tr>
<tr>
<td>Code of Practice : Physical Restraint</td>
</tr>
<tr>
<td>Code of Practice, Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge</td>
</tr>
</tbody>
</table>

2.8 Areas of good practice identified on this inspection

- Red apron campaign for medication management
- Quarterly auditing of Individual Care Plans (ICPs) and feedback to staff
- Activity programmes for residents
- Family / carers involvement in multi-disciplinary team (MDT)
- Warm and dignified manner in which staff interacted with residents
- Continual improvement planning for the service and St Anne’s Unit
- Yearly planning addressing identified training needs
2.9 Reporting on the National Clinical Guidelines

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

2.10 Resident Interviews

No resident asked to speak directly with the inspectors but the inspectors held brief conversations with several of the residents during the course of the inspection. Residents who spoke indicated their satisfaction with the service and staff.

2.11 Feedback Meeting

A feedback meeting was held with senior management before the conclusion of the inspection. This was attended by

- Registered Proprietor
- Executive Clinical Director
- Area Director of Nursing
- OT Manager nominee
- Principle Psychologist
- Principle Social Worker
- Two Consultant Psychiatrists
- CNM 3
- Assistant Director Of Nursing

The inspection team gave feedback on the Regulations, Rules, Codes of Practice inspected during the course of the inspection. Issues highlighted by the inspection team included identification of residents in clinical records, residents’ property, recording of controlled drug use and maintenance of records.

The inspection team heard from the senior management team regarding ongoing improvement to St Anne’s Unit and that there were plans to refurbish the unit to have individual bedrooms and en suites. There was agreement to look at integrated clinical files and examples of this existed in other parts of the service. The inspection team were thanked for the feedback on the inspection which was welcomed.
### 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)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1</strong> Regulation 1: Citation</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>3.2</strong> Regulation 2: Commencement</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>3.3</strong> Regulation 3: Definitions</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
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: There was a process in place to identify residents. On admission, this was done using name, date of birth, address and photograph taken, and then used on addressograph on documentation, i.e. clinical file and medication kardexes.

Training: Responsibility for the training of staff and students on the process was the CNM’s on the unit and also the staff nurses. Staff were aware of the process and their responsibility.

Monitoring of Compliance: There was no evidence of monitoring to adherence of the process; however, it was evident that in an audit taking place on the medication administration records, identification of residents was used as a criteria to be audited against.

Evidence of Implementation: There was evidence of more than two identifiers being used to identify residents and these are applied on both charts and kardexes. Staff were able to outline the process of identification.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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:* Roles and responsibilities were evident across nursing, medical, catering and dietician staff in the unit.

*Training:* Staff were aware of their roles in the provision food and nutrition. Training of staff in the management of dysphagia was evident from interview with staff.

*Monitoring of Compliance:* Nursing staff monitored intake, diet, weight and specific needs relating to dysphagia and recorded same as part of the ICP.

*Evidence of Implementation:* Assessment of nutritional need of the residents was evident within the ICP. Observation of the dining room on two occasions during mealtimes revealed a pleasant space with plenty of accommodation for the residents to enjoy their meals. Meals were prepared in the kitchen in the Sacred Heart Hospital and delivered to the unit on hot trolleys and served through a hatch between the unit's kitchen area and dining room. The food provided was based on residents’ choice from a menu which was displayed in the dining room in a number of formats. These included a pictorial representation and a written version and there was a choice of meals daily with special diets being catered for. Discussion between staff and residents about their diet was observed. Water was available in the dining room in jugs and was regularly given out across the day.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
### 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 Services Manager of the Sacred Heart Hospital was responsible for the provision and management of food delivered to St Anne’s Unit. The household staff within the unit were responsible for the handling and distribution of food on the unit.

**Training:** Training in the Hazard Analysis Critical Control Point process for food safety was used in Sacred Heart Hospital. Staff in St Anne’s Unit involved in the handling of food were also trained in food safety.

**Monitoring of Compliance:** The Environmental Health Officer’s report from 17 April 2015 was inspected and this was compliant with food legislation. Household staff on St Anne’s were observed by inspectors to be monitoring the fridge and food temperatures.

**Evidence of Implementation:** The inspector met with the Services Manager of the Sacred Heart Hospital and visited the kitchen and examined food safety records. The dining room was clean, bright and uncluttered. The table settings had cutlery, napkins and crockery appropriate to residents’ needs. The servery kitchens contained heated food trolleys, refrigeration and dishwashing facilities and storage presses. Food was delivered fully cooked in heated trolleys from the Sacred Heart Hospital. Catering staff checked, recorded and monitored food temperatures and the temperature of the refrigerator. The cleaning schedule was also recorded and monitored. All refuse waste was separated and disposed outside the unit. Household staff had separate changing and handwashing facilities.

### Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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: There was a policy on the use of night attire and there was a clear process whereby residents were dressed, had their own clothing and an adequate supply of individualised appropriate clothing.

Training: Staff demonstrated awareness of the policy and processes related to residents’ clothing.

Monitoring of Compliance: Staff oversaw residents’ self-care and so were monitoring residents’ clothing needs and there was a process for addressing this need. Property checklists were maintained throughout the residents’ admission.

Evidence of Implementation: All residents were up and dressed in age appropriate day clothing at the start of the inspection process (0930h). Residents had their own allocated wardrobe and it was evident on inspection that all clothes were labelled and that the residents had adequate supplies of clothing available. The residents had their own clothing that was individualised and gave the residents dignity and integrity.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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: There was a policy and process in relation to residents’ personal property and possessions.

Training: All staff sign policy to state awareness and understanding of the policy and procedures in relation to residents' personal property. However, on enquiry by inspection team, staff were not able to clearly articulate procedures.

Monitoring of Compliance: The property checklists inspected were updated but not countersigned. There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: The clinical files of all six residents were inspected and property lists were up to date. Many residents did not have capacity to manage their own property. The petty cash records for residents were inadequate as they did not contain two signatures for withdrawals and were maintained on loose sheets. There was no information on resident’s capacity to consent or family / carer involvement in the process and no information on where the monies were spent.

Each resident had an individual wardrobe that was not lockable; however, there was no recorded incidents of property going missing or complaints recorded from families about property going missing. Staff outlined that there had been no difficulties in this regard. There was a safe in the clinical room and the control of this was maintained by the CNM on the unit.

The approved centre was deemed to be non-compliant with this regulation because the petty cash records for the residents were inadequate.
<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Rating:</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Critical</th>
<th>Not - Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
<td><img src="x" alt="X" /></td>
</tr>
</tbody>
</table>
3.8 Regulation 8: Residents' Personal Property and Possessions

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

<table>
<thead>
<tr>
<th>Date submitted</th>
<th>19th November, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPAs</td>
<td>Specific</td>
</tr>
<tr>
<td>Define the action <strong>and</strong> state if it is corrective or preventative <strong>and</strong> state post-holder(s) responsible</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
</tr>
</tbody>
</table>

**1. Regulation 8 – Residents’ Personal Property and Possessions**

**Corrective.**
New patients’ cash system implemented – requiring two signatures (staff / carer) and a six month audit. The new system clearly shows reasons for withdrawals. Cash sheets are no longer loose, they are bound in a book and have sequential page numbers. Receipts are now kept in individual patient folders. Any issue around capacity to consent are documented in the Individual Care Plan.

Post-Holder(s): Teresa Garrett CMN3, Rose Malone, Business Manager, Eugene McCormack, Asst DON

The approved centre was deemed to be non-compliant with this regulation because the petty cash records for the residents were in adequate.

A six monthly audit of records.

Already achieved.

Complete.
### 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:** There were defined processes in place that ensured residents were assessed and supported to pursue meaningful recreational activities. There was an activities nurse assigned to the unit with responsibility for recreation provision.

**Training:** Staff were aware of the processes of individual assessment and the individual recreational plans for the residents.

**Monitoring of Compliance:** Each resident’s needs in relation to recreation were recorded and monitored. There was a plan for the review and improvement of the recreation programme.

**Evidence of Implementation:** There were communal spaces for recreation in the day room with a TV, DVDs, books, magazines, a music system and an exercise machine. The outdoor space was tarmacadamed for ease of use by the residents and wheelchair accessibility and it contained raised planted areas and colourful paintings and areas for walking. There was a dedicated recreation activities room also which was used for structured activities such as hand massage and reminiscence therapy or music therapy.

Each resident’s needs had been assessed and recorded in the individual resident’s clinical file and a format used to explore their own views was employed. This culminated in a “My Life Story” record for each resident. There was a pre organised event where a mobile farm came to the unit on the second day of inspection, which gave residents and staff a very engaging experience. It was apparent that there was meaningful attention placed upon recreation and activities for the residents.

#### Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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: A policy on cultural diversity in Mayo Mental Health Services (MMHS) was in place that outlined roles and responsibilities in the application of religious practices for the individual resident’s beliefs. There was a process for the recording of a resident’s religion on admission.

Training: Staff were aware of the policy and how to apply the policy where necessary.

Monitoring of Compliance: There was no evidence of monitoring of the process. However, recording of religious status obtained on admission to guide staff in resident’s religious needs.

Evidence of Implementation: There was a church on the site of the Sacred Heart Hospital adjacent which residents could access if they so wished. However, due to the nature and mobility of the residents, services were brought to the unit in the form of holy communion brought to the ward and priests would visit on request and the staff would facilitate this.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: There was a defined process and policy in relation to visits for facilitating visiting to the unit. There was a designated visiting room and times were prominently displayed and flexibility of the visiting was facilitated to assist families. Child visiting was supervised by responsible adults.

Training: Staff demonstrated awareness of the policy and process for visiting.

Monitoring of Compliance: There was no evidence of monitoring against the process. There was monitoring of visitors on entry and exit as the unit was a locked unit and from the residents’ nursing notes, there was evidence of recording of interaction with families and visitors and assessment of how visiting had gone.

Evidence of Implementation: There was no restriction on visitors to any resident. The visiting room was spacious and there was also a veranda that was used with access to the garden area. Visiting time information was displayed and part of the unit’s information leaflet. Staff reported that they could have refreshments with their relative during visits.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Ref MHC – FRM – 001- Rev 1
The text contains a regulatory section on communication, including requirements and inspection findings. It states that residents are free to communicate at all times, with due regard to their wellbeing, safety, and health. The clinical director or a designated staff member can examine communication if there is reasonable cause for belief that it may result in harm to the resident or others. The registered proprietor must ensure written policies on communication. The regulation defines communication as the use of mail, fax, email, internet, telephone, or any device for sending or receiving messages or goods.

**Inspection Findings**

**Processes:** There was a defined process and policy on communication outlining the requirements of the regulation. As the centre caters for residents with cognitive difficulties, there were processes for assessing residents' communication needs. 

**Training:** Staff were able to articulate the processes and demonstrated awareness of the policy.

**Monitoring of Compliance:** There was no evidence of monitoring of adherence to the policy. Monitoring involved assessment at admission and ongoing assessment by the Multi-Disciplinary Team (MDT).

**Evidence of Implementation:** There was no public phone on the unit. However, residents had access to a cordless phone that staff would assist in using. Most residents had dementia and required assistance for communication needs. The unit maintained a daily postal service to and from the units, and this mail was not examined by staff.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
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: There was a defined process and policy on searches that outlined the requirements of the regulation.

Training: Staff were aware of the policy and the process of searching

Monitoring of Compliance: There was no evidence of monitoring of the search process as there had been no searches carried out.

Evidence of Implementation: There was no evidence of implementation of the search process as there had been no searches carried out.

Compliance was assessed against policy, processes and training.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Ref MHC – FRM – 001- Rev 1

Page 21 of 59
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: Detailed policy was in place outlining the roles, responsibilities and procedure for care of the dying within the approved centre

Training: Nursing staff were aware of the policy and the processes involved in the care of the dying patient as per their nursing training.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the process. The centre maintained records of deaths as part of their incident reporting. They also sent notifications of deaths to the MHC.

Evidence of Implementation: There had been one death of a resident since last inspection and this resident died in Mayo General Hospital. The MHC were notified within the required timeframe. There were single rooms in St Anne's that could be used for care of the dying resident if necessary. There were no Do Not Attempt Resuscitation (DNAR) orders in use during inspection.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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: There were clear processes to ensure each resident had an individual care plan (ICP). ICPs were developed post admission by the MDT. Family involvement was evident where the resident's capacity to provide information was compromised and with the resident where they had capacity – their input was sought and recorded. Admission and ongoing assessment was comprehensive with the use of several evidence based assessments being used to inform care planning.

Training: All members of the MDT were aware of the care planning process and received onsite training by heads of departments. Awareness was evident on examination of the ICP documents.

Monitoring of Compliance: ICPs were reviewed monthly by the MDT and the ICPs were audited quarterly by a CNM2 in the practice development office and feedback provided to staff on the unit.

Evidence of Implementation: Each resident had an ICP developed by the MDT. The MDT consisted of Consultant, NCHD, Nursing Staff, Occupational Therapist, Psychology, Social worker and a recently appointed Dietician.

ICPs were based on individual assessment of the resident with collateral from families or carers. ICPs inspected showed goal identification; targeted interventions assigned to specific team members responsible for that area; recorded regular reviews (monthly); family input and views; delivery of the care and interventions; and recorded outcomes. Each resident had a key worker assigned to them who had responsibility for coordinating care from admission through to discharge. ICPs included up-to-date risk assessments that informed care. The ICP recorded whether residents had capacity to be involved in their care planning and, where they did, they were involved in the process and signed to that effect. Where a resident declined to be involved, this was recorded also.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
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: There was a defined process to ensure residents had access to a range of therapeutic services and programmes.

Training: All staff providing therapeutic services and programmes were trained mental health professionals with experience of provision of therapeutic programmes.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the process. There was an audit of the ICP’s by the CNM on a 3 monthly basis that captured this.

Evidence of Implementation: Each resident’s ICP contained assessments under domains of care and from this was developed individualised care plans that allowed for the therapeutic needs of the resident to be set out, goals and interventions to be outlined and therapeutic inputs to be accounted for. There was good evidence of interventions by a well-resourced MDT psychiatry of old age team and outcomes achieved. The types of therapeutic services available in the centre included Dietetics, Speech and Language, Occupational Therapy, Social work, Clinical Psychology and Physiotherapy.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 Children were not admitted to this approved centre, this regulation was not applicable.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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: There was a policy on the transfer of residents and the process involved medical and nursing transfer documentation being sent with the resident.

Training: There was awareness of the policy and process by staff.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: The clinical files of two residents recently transferred to Mayo General Hospital were inspected. All relevant clinical information accompanied the residents on transfer.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Non-Compliant – Negligible Achievement (1)</th>
<th>Non – Non-Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
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: There was a policy on the management of medical emergencies and processes evident for the management of general physical health needs of the residents.

Training: The medical and nursing staff all had training in general health management and demonstrated awareness of the policy on medical emergencies. An ongoing training programme was in place and training logs were maintained.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the process.

Evidence of Implementation: Medical and nursing staff provided ongoing management of residents’ general healthcare needs and access to outside healthcare where appropriate was observed in clinical files. The ICPs of the residents identified general health needs and residents that were there over six months had physical reviews completed. Staff were aware of how to access national screening programmes as required for residents.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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: There was a policy on the provision of information to residents. There was a clear process for the provision of written and verbal information to residents and families.

Training: All staff were trained healthcare professionals and several had completed training in dementia care. Part of this training included provision of information to residents who have cognitive impairments.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy; however, each resident’s clinical file contained information on what a resident’s need was in relation to communication.

Evidence of Implementation: There was an information booklet available on the unit and this satisfied the requirements of the regulation 20 part 1(a)(b)(c). Advocacy information was also displayed within the unit. There was an information folder in the day room that provided information on dementia and other psychiatric diagnoses relevant to the unit’s residents. There was information available also on treatments and medications and staff photocopied these for families and residents, as appropriate. Individual assessment of communication needs formed part of care planning. Capacity of a resident to understand information giving was noted on the clinical file.

There was information available for patients who would be detained under MHA legislation as to their rights.

Staff were observed using different styles of communication based on the individual needs of the resident in pictorial, written and verbal formats.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>

Ref MHC – FRM – 001- Rev 1
### 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:** Staff demonstrated awareness of the right to dignity and respect and privacy of all residents.

**Training:** Staff were all trained healthcare professionals and several staff had training in dementia care and protection of vulnerable adults.

**Monitoring of Compliance:** There was no evidence of monitoring of adherence to the process.

**Evidence of Implementation:** The inspection team observed the staff caring for the residents in St Anne’s interacting with the residents in a respectful and calm unhurried manner and in a natural way of conversing.

All residents were appropriately dressed and groomed and individual help with their Activities of Daily Living (ADL’s) were provided with dignity and respect.

All residents’ bedrooms had curtains on the windows and around each bed.

There was sufficient space within the unit to provide for maintaining privacy when completing healthcare procedures and discussion of residents’ care. The clinical records inspected showed a culture of awareness of the needs of residents with respect and dignity at their core. No confidential information was on public display.

#### Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
### 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.


### Inspection Findings

Processes: There was a process in place for access to maintenance on site at the Sacred Heart Hospital and also there was an ongoing capital development programme with responsibility for upgrading the premises.

Training: Staff were able to articulate the process for ongoing maintenance.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the process. However, there was evidence of monitoring of hygiene and cleaning. Schedules for same were present throughout the unit.

Evidence of Implementation: The unit was well lit, heated and ventilated, had an adequate level of space for the residents, furnished to a good standard with good indoor and outdoor spaces that residents could access and was in very good decorative appearance throughout. It had access for disabled users throughout the building. There was an active approach to maintenance and cleaning of the unit.

Since the last inspection, there had been a complete renovation of the roof of the unit and plumbing issues had also been addressed. Upgrades to the fire protection systems had also been completed.
## Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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.


Inspection Findings

Processes: There was a policy on the management of medication. The policy outlined the responsibilities in relation to the ordering, prescribing, storing and administration of medicines to residents.

Training: Training on these processes was received as part of the clinical staff’s professional training. A preceptorship programme was in place for student nurses to be trained in medication processes.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy. There was an audit of medication kardexes that was done in October 2015; however, this was very limited in its scope.

Evidence of Implementation: Medication was ordered and delivered via the pharmacy in Mayo General Hospital and delivered to the unit in locked boxes or collected as necessary by clinical staff. Medications were stored in a locked trolley and in locked presses in a clinic room which was also locked. All six kardexes in use in the unit were assessed on inspection. There was evidence of documenting refusals and non-administration of medication in both the kardexes and the nursing notes. Staff were aware of reporting of medication error responsibilities. The kardexes did not contain signatures of prescribers in the signatures bank as per the centre’s own guidance. Stopping of medication was not accounted for on two of the kardexes examined by the person stopping the medication.

Administration of medication was observed on the second day of inspection and hand hygiene and the use of resident identifiers were evident. Two registered nursing staff administered the medication. Controlled drugs were stored securely and ordering and prescribing was observed. Recording of the controlled drugs stock balance was maintained in a locally produced document book which had pages stapled into it and did not have sequential page numbers. The controlled drugs recording register was not made available on the day of inspection but was made available subsequent to the inspection.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ref MHC – FRM – 001- Rev 1 Page 32 of 59
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: There was a policy that was site specific to St Anne’s Unit for Health and Safety and there was also a risk management policy. There was a safety representative in the service.

Training: Regular training was evident in training logs maintained at the centre for Basic Life Support (BLS), Manual Handling and Fire Training.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: It was clear that there was an awareness of roles and responsibilities in relation to fire safety procedures as the fire alarm was activated twice during inspection and staff implemented their roles well. There was safety signage and equipment maintained in the unit. Fire exits were clearly marked and fire break glass units deactivate locks on external doors. There was an emergency plan for the service. Staff demonstrated awareness of National Guidance on Infection Control. Incident logs were maintained. There was evidence of continuing risk assessment at individual resident level and at organisational level.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non–Compliant – Negligible Achievement (1)</th>
<th>Non–Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not–Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
3.25 Regulation 25: Use of Close Circuit Television (CCTV)

(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

There was no CCTV in use in St Anne’s Unit. This regulation was not applicable.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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 HSE policy on the recruitment, selection, vetting and appointment of staff applied to the centre. Appointments were made through the national recruitment service in the HSE. There was a clear process of rostering staff that identified staffing needs appropriate to the unit. There was a clearly identifiable and appropriately qualified person in charge at all times.

Training: Staff were trained commensurate with their roles, there was a clear process for access to education of staff and this was facilitated in conjunction with the Centre for Nurse Midwifery Education. There was a defined induction process for new staff performed on site with supervision by existing staff.

Monitoring of Compliance: Staffing levels and skills mix were reviewed on an ongoing basis by the senior management team. Heads of departments reviewed training needs annually and this informed the training needs.

Evidence of Implementation: On the day of inspection there was 1 x CNM3, 1 x CNM2, 2 x RPNs, 2 x HCAs, 3 Multi Task Assistants and at night there was 1 x CNM3 (in charge shared across MMHS) 2 x RPNs and 1 x HCA. There was a copy of Mental Health Act, regulations and the Codes of Practice available to staff in the Centre. Residents had access to a full MDT and clinical files showed input from several disciplines appropriate to the residents' needs and access to external services was also evident.

Two Human Resource files were inspected and these contained evidence of curriculum vitae, Garda vetting, references, professional qualification and registration, where appropriate, identification and contract of employment.
<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
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.


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 centre had a policy on the Management of Clinical Records and this outlined process in relation to creation, access to, retention of and destruction of records.

Training: Staff were aware of the policy and process. Training on Best Practice in Recording Clinical Care noted in the schedule of educational learning events for 2015-2016.

Monitoring of Compliance: There was no monitoring of adherence to the policy evident.

Evidence of Implementation: The Environmental Health Officer report was available and inspected.

Six residents’ clinical files were inspected and these were maintained in good order with structure and divisions within the file. The files were maintained in an open trolley within the nursing office.

The files were, however, not maintained in an order that facilitated ease of navigation or retrieval of information and it was difficult to ascertain if the care given to residents was of a cohesive fashion. It was difficult to assess sequential events as the medical and nursing and other discipline notes were maintained separately within the file. This did not allow for a contemporaneous view of the care given to residents.

Medical notes were observed to be in poor condition in relation to the identification of residents and the recording of the timeline of the notes. Evidence was seen of no resident identifiers being used or just one identifier being used and times of notetaking were not included on all entries.

The approved centre was deemed to be non-compliant with this regulation because of the method of maintaining the clinical records.
### Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Risk Rating:

- **Low**
- **Moderate**
- **High**
- **Critical**
- **Not Applicable**

<table>
<thead>
<tr>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Critical</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.27 Regulation 27: Maintenance of Records

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

<table>
<thead>
<tr>
<th>Date submitted</th>
<th>19th November, 2015</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CAPAs</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable &amp; Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
<td>State method of evaluation and monitoring of outcome</td>
<td>State feasibility of action</td>
<td>State time-frame for completion of action</td>
</tr>
</tbody>
</table>

#### 1. Regulation 27: Maintenance of Records

Corrective.

Navigation of notes and retrieval of information, will be improved by archiving corresponding nursing and medical notes each quarter. This will make it easier to ascertain that the care given to residents was of a cohesive fashion. It will also make it easier to assess sequential events when reading patients notes. The identification of patients in medical notes has been enhanced by placing addressographs on each page and this will be audited monthly. Medical staff have been reminded to include the time their entries are made.

Post-Holder(s): Teresa Garrett, CMN3, Rose Malone, Business Manager, Eugene McCormack, Asst DON

The approved centre was deemed to be non compliant with this regulation because of the method of maintaining clinical records.

Monthly audit.

Monthly audit implemented

Two months.
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

There was an up-to-date register of residents made available to the inspector. It was maintained in electronic format and contained all elements of schedule 1 to the Regulations.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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: There was a policy in relation to policy and procedures which was a HSE-wide policy. St Anne’s policies were developed by the MMHS policy group which adhered to the defined process as laid out in HSE-wide policy. Policies in the unit were maintained on computer.

Training: Staff and Heads of Departments displayed awareness of their roles in the development of policies and procedures.

Monitoring of Compliance: Policies for the approved centre were in date and reviewed by a policy review committee that consisted of senior managers.

Evidence of Implementation: The policies provided to the inspectors were laid out and approved in accordance with the HSE policy on operating policies and procedures. All policies presented for inspection had been reviewed within three years, as required by the regulation.

Compliance Rating:

<table>
<thead>
<tr>
<th>Compliance Rating</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>


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

Processes: There was a process for facilitating Mental Health Tribunals within the Centre.

Training: Staff were aware of the process and could articulate same.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the process.

Evidence of Implementation: A Care plan/checklist was seen from recently discharged resident who had been detained to the centre. There were no detained patients in the centre on inspection. Adequate resources and private facilities were provided by the centre to support the Mental Health Tribunal Process.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>


3.31 Regulation 31: Complaints Procedure

(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 service had a policy in relation to feedback and there was a local complaints procedure in St Anne’s.

Training: Staff demonstrated an awareness of the complaints/comments process and policy and how to manage same.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy. There was a complaints log in the unit.

Evidence of Implementation: Complaints procedures were displayed prominently in several areas around the unit. There was a nominated person in the centre allocated to deal with complaints. This was identified as the Nurse in Charge of the unit. Advocacy services were available to the residents. There was a record of complaints maintained in the unit in the complaints log.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.32 Regulation 32: Risk Management Procedure

(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:** There were risk management policies for Mayo Mental Health Service and St Anne’s that addressed the risks specified within the regulation and there was an identified risk manager for the service. In addition to the Risk Management policy, there was a very comprehensive HSE policy ‘Safety, Incident Management Policy’. There were clear processes for the identification, recording and investigation of incidents within the service and the unit.

**Training:** Staff were trained in the use of risk management tools and the reporting of incidents and there was an awareness of the roles and responsibilities relating to this.

**Monitoring of Compliance:** The risk assessment form used in St Anne’s was updated annually. There was a risk register that was monitored and updated on an ongoing basis. There were audits of incidents on the unit by the CNM3. Incident reports were completed and reviewed and escalated in accordance with the policy.

**Evidence of Implementation:** Each resident had risk assessments applied to their care as was appropriate and these were reviewed and updated as part of the MDT reviews of the ICPs and families were involved in the decision making processes arising.

The incident report book showed that incidents were reviewed by the MDT and reported to the senior management team. The risk manager advised that there was a review of incidents and risk register by the management team. The centre sent a six month summary of the incidents for the period January to June 2015 to the MHC.
<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
### 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 was insured under the national indemnity scheme; the State Claims Agency. The certificate of Insurance was inspected.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="x" alt="X" /></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### 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.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non – Compliant – Negligible Achievement (1)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
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 or unwilling 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

ECT was not provided at the approved centre and no patient was receiving ECT in another centre. This regulation was not applicable.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Poor Achievement (1)</th>
<th>Non – Compliant – Good Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

x
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”.

<table>
<thead>
<tr>
<th>Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Resident was placed in seclusion at this centre. There were no seclusion facilities at the approved centre. This regulation was not applicable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non – Compliant – Negligible Achievement (1)</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
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: There was a policy on mechanical restraint in the approved centre. Mechanical restraint was used at the centre but only in respect of Part 5 of the Rules governing the use of seclusion and mechanical means of bodily restraint.

Training: Staff were trained in the application of mechanical restraint.

Monitoring of Compliance: There was comprehensive monitoring of the mechanical restraint in use for one resident apparent in the residents clinical file seen by inspection team.

Evidence of Implementation: Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others, was used in the case of one resident in the centre by way of lap belt. The process of assessment, prescription, monitoring, review and ongoing assessment of the need for mechanical restraint in this case was evident in the recording of same in the resident’s clinical file.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 or unwilling 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

There were no detained patients at the approved centre. Part 4 of the Mental Health Act did not apply.
<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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: There was a policy for the management of physical restraint that met the requirements of the Code of Practice.

Training: Staff were aware of the policy on physical restraint. There was mandatory training in Management and Prevention of Aggression for staff. There was also training specific to the resident needs completed, i.e., Challenging Behaviour in the Elderly, Elder Abuse Recognition and Response and Dementia Care.

Monitoring of Compliance: Incident reports were completed for episodes of physical restraint and these were reviewed as part of risk management processes. An audit was completed monthly on the use of physical restraint.

Evidence of Implementation: No current resident had been physically restrained. The clinical practice book was inspected and there was one entry for 2015.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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**

No children were admitted to this unit. This regulation was not applicable here.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
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 policies on Death and Dying, Risk Management, Incident Management and the process of Notification of Death to the MHC was documented within these.

*Training:* The staff of St Anne’s demonstrated awareness of the policies and processes involved in reporting incidents and deaths.

*Monitoring of Compliance:* There was no evidence of monitoring of adherence to the process.

*Evidence of Implementation:* The approved centre had completed and sent the Notification of Death form concerning the one death in the approved centre to the MHC and had also sent the incident report summary for the relevant periods to the MHC.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
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: There was a policy on persons working in mental health services with people with an intellectual disability.

Training: Staff were trained in the care and management of intellectual disability and mental illness. MMHS provided training to staff on working with residents with intellectual disabilities.

Monitoring of Compliance: There was an audit of the ICPs each quarter on the unit which would capture any issues arising in the care of a resident with intellectual disabilities.

Evidence of Implementation: One resident had an intellectual disability and a mental illness. The clinical file showed comprehensive information on the resident’s needs and history from the intellectual service that the resident had come from. There was a cognitive assessment in place. The file showed that the resident did not have capacity and that he was supported in decision-making by his family and the MDT. The family were involved in the resident’s ICP process attending the MDT review. Staff were observed to care for and give treatment to this resident in a manner that demonstrated the guiding principles of the code of practice. This was client-centred, in his best interests, was the least restrictive, and cognisant of his lack of capacity to consent.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not-Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non – Compliant – Negligible Achievement (1)</td>
</tr>
<tr>
<td>x</td>
</tr>
</tbody>
</table>

Inspection Findings

ECT was not provided at the approved centre and no patient was receiving ECT in another centre. This was not applicable.
6.6 Admissions, 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: There were policies on the Admission, Transfer and Discharge of a resident specific to Mayo Mental Health Services. There were processes that facilitated pre-planned admissions to St Anne’s. There was a policy on the role of the key worker.

Training: Staff were aware of the policies on admission, transfer and discharge. The role of the key worker was also clearly laid out.

Monitoring of Compliance: Checklists were used on admission and for transfers. On discharge, a nursing report with standardised features was written up and this allowed for monitoring of that process. The MDT reviewed the discharge planning as part of ICP process to ensure seamless transition upon discharge of a resident.

Evidence of Implementation: The clinical files of the most recently admitted and discharged residents were inspected and the clinical files of residents transferred were also inspected.

Admission:
One resident was admitted from Mayo General Hospital and admission assessment was done by the NCHD on call who made the decision to accept admission. The NCHD performed a comprehensive psychiatric assessment and physical assessment. Individual risk assessment was performed and a risk management plan was implemented. An initial care plan was in place and resident refused to sign care plan. MHA information was given to the patient. Family members were involved and met for collateral history.

Transfer:
The clinical files of two residents who were transferred to Mayo General Hospital were inspected. The residents had been accompanied on transfer. A medical referral letter and nursing letter and a copy of the kardexes were sent with the residents. Nursing staff liaised with staff in Mayo General Hospital throughout the residents’ stay and updated the clinical records in St Anne’s. The re-admission to St Anne’s was also managed in liaison with the staff in Mayo General Hospital. Families were also informed about planned transfers.

Discharge:
MHA detention order revoked and resident discharged to care of family. Resident declined any follow up care offered. Risk assessment evident prior to discharge and family meeting also prior to discharge, prescription written for GP. And letter to follow to GP noted by consultant. GP contacted to hand over care via phone on day of discharge. A medical discharge summary was subsequently prepared and sent to the GP and their discharge summary was awaiting filing in the clinical file.
## Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
<th>Not–Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>