# Approved Centre Inspection Report (Mental Health Act 2001)

<table>
<thead>
<tr>
<th>Approved Centre Name</th>
<th>St Anne’s Unit, Sacred Heart Hospital</th>
</tr>
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<tbody>
<tr>
<td>Identification Number</td>
<td>AC0072</td>
</tr>
<tr>
<td>Approved Centre Type</td>
<td>Psychiatry Of Old Age</td>
</tr>
<tr>
<td>Registered Proprietor</td>
<td>HSE</td>
</tr>
<tr>
<td>Registered Proprietor Nominee</td>
<td>Mr Steve Jackson</td>
</tr>
<tr>
<td>Most Recent Registration Date</td>
<td>1 October 2014</td>
</tr>
<tr>
<td>Number of Residents Registered For</td>
<td>12</td>
</tr>
<tr>
<td>Inspection Type</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Inspection Date</td>
<td>25, 26, 27 &amp; 28 October 2016</td>
</tr>
<tr>
<td>Previous Inspection Date</td>
<td>15 &amp; 16 October 2015</td>
</tr>
<tr>
<td>Conditions Attached</td>
<td>None</td>
</tr>
<tr>
<td>Lead Inspector</td>
<td>Mr Donal O’Gorman</td>
</tr>
<tr>
<td>Inspection Team</td>
<td>Ms Ann Wallace</td>
</tr>
<tr>
<td></td>
<td>Ms Siobhán Dinan</td>
</tr>
<tr>
<td>The Inspector of Mental Health Services</td>
<td>Dr Susan Finnerty MCN009711</td>
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</tbody>
</table>
Contents
1.0 Mental Health Commission Inspection Process ............................................................... 4
2.0 Approved Centre Inspection - Overview ......................................................................... 6
  2.1 Overview of the Approved Centre .................................................................................. 6
  2.2 Conditions to Registration ........................................................................................... 6
  2.3 Governance .................................................................................................................... 6
  2.4 Inspection scope ............................................................................................................ 6
  2.5 Non-compliant areas from 2015 inspection ................................................................... 6
  2.6 Corrective and Preventative Action plan ....................................................................... 7
  2.7 Non-compliant areas on this inspection ......................................................................... 7
  2.8 Areas of compliance rated Excellent on this inspection ................................................. 7
  2.9 Areas not applicable ...................................................................................................... 7
  2.10 Areas of good practice identified on this inspection ..................................................... 8
  2.11 Reporting on the National Clinical Guidelines .............................................................. 8
  2.12 Section 26 Mental Health Act 2001 - Absence with Leave .......................................... 8
  2.13 Resident Interviews .................................................................................................... 8
  2.14 Resident Profile .......................................................................................................... 9
  2.15 Feedback Meeting ....................................................................................................... 9
3.0 Inspection Findings and Required Actions - Regulations ............................................... 11
  3.1 Regulation 1: Citation ..................................................................................................... 11
  3.2 Regulation 2: Commencement ....................................................................................... 11
  3.3 Regulation 3: Definitions .............................................................................................. 11
  3.4 Regulation 4: Identification of Residents ....................................................................... 12
  3.5 Regulation 5: Food and Nutrition .................................................................................. 13
  3.6 Regulation 6: Food Safety ............................................................................................. 15
  3.7 Regulation 7: Clothing .................................................................................................. 16
  3.8 Regulation 8: Residents’ Personal Property and Possessions ....................................... 17
  3.9 Regulation 9: Recreational Activities .......................................................................... 19
  3.10 Regulation 10: Religion ............................................................................................... 20
  3.11 Regulation 11: Visits ................................................................................................... 21
  3.12 Regulation 12: Communication .................................................................................. 22
  3.13 Regulation 13: Searches ............................................................................................. 23
  3.14 Regulation 14: Care of the Dying ................................................................................. 24
  3.15 Regulation 15: Individual Care Plan ............................................................................ 26
  3.16 Regulation 16: Therapeutic Services and Programmes ............................................... 27
  3.17 Regulation 17: Children’s Education ......................................................................... 28
  3.18 Regulation 18: Transfer of Residents ......................................................................... 29
  3.19 Regulation 19: General Health .................................................................................. 30
3.20 Regulation 20: Provision of Information to Residents .................................................. 32
3.21 Regulation 21: Privacy .................................................................................................. 34
3.22 Regulation 22: Premises ............................................................................................. 35
3.23 Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines ........ 37
3.24 Regulation 24: Health and Safety ................................................................................. 39
3.25 Regulation 25: Use of Closed Circuit Television .......................................................... 40
3.26 Regulation 26: Staffing ............................................................................................... 41
3.27 Regulation 27: Maintenance of Records ...................................................................... 43
3.28 Regulation 28: Register of Residents ......................................................................... 45
3.29 Regulation 29: Operating Policies and Procedures ....................................................... 46
3.30 Regulation 30: Mental Health Tribunals ..................................................................... 47
3.31 Regulation 31: Complaints Procedures ........................................................................ 48
3.32 Regulation 32: Risk Management Procedures .............................................................. 50
3.33 Regulation 33: Insurance ............................................................................................. 52
3.34 Regulation 34: Certificate of Registration ................................................................... 53

4.0 Inspection Findings and Required Actions - Rules ....................................................... 54
4.1 Section 59: The Use of Electro-Convulsive Therapy ...................................................... 54
4.2 Section 69: The Use of Seclusion ................................................................................. 55
4.3 Section 69: The Use of Mechanical Restraint ............................................................... 56

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001 .................. 57
5.1 Part 4: Consent to Treatment ......................................................................................... 57
6.1 The Use of Physical Restraint ....................................................................................... 58
6.2 Admission of Children ................................................................................................. 60
6.3 Notification of Deaths and Incident Reporting ............................................................. 61
6.4 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities ........................................................................................................... 62
6.5 The Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients ....................... 63
6.6 Admission, Transfer and Discharge ............................................................................. 64

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016 ........................................................................................................................................ 66
1.0 Mental Health Commission Inspection Process

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

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

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

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

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

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

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.
The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART).

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

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

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

2.1  Overview of the Approved Centre

The approved centre was located on the grounds of and attached to the Sacred Heart Hospital in Castlebar, Co. Mayo. The approved centre was locked and situated on ground level. It was a single storey building dating back to the 1970’s. It was a 12 bedded residential unit which catered for people with dementia resulting in challenging behaviour. In this unit, assessment, interim care, continuing care and limited respite care was provided for people over 65 years old. On the days of inspection there were six residents, four male and two female residents. All residents were voluntary.

2.2  Conditions to Registration

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

2.3  Governance

There was an organisational chart and clear governance structures and processes in place. Minutes of the Mayo Mental Health Services Management Team Meetings were provided to the inspection team and evidenced regular senior management meetings and governance structures which addressed issues such as risk register, key performance indicators, policies and quality and patient safety.

2.4  Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against

The inspection was undertaken onsite in the approved centre from:

- 25th October 2016 at 10.00 to: 25th October 2016 at 17.30
- 26th October 2016 at 09.00 to: 26th October 2016 at 17.30
- 27th October 2016 at 09.00 to: 27th October 2016 at 17.30
- 28th October 2016 at 09.00 to: 28th October 2016 at 16.00

2.5  Non-compliant areas from 2015 inspection

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

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Inspection Findings 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8  Residents’ Personal Property and Possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 27  Maintenance of Records</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

Ref MHC – FRM – 001- Rev 1
2.6 Corrective and Preventative Action plan

St Anne’s Unit, Sacred Heart Hospital provided CAPA’s following the 2015 inspection to address areas of non-compliance. These were, as follows:

**Regulation 8: Residents’ Personal Property and Possessions:** The approved centre was deemed non complaint with this regulation because the petty cash records for the residents were inadequate. There was a new residents’ cash system implemented, requiring two staff signatures and a six monthly audit to review these processes. The new cash system clearly showed reasons for withdrawals. Any issue around capacity to consent were documented in the individual care plan.

**Regulation 27: Maintenance of Records:** The approved centre was deemed non complaint with this regulation because of the inadequate method of maintaining clinical records. Navigation of clinical notes and retrieval of information improved through the archiving of both medical and nursing notes each quarter. The identification of residents in medical notes had been enhanced by placing addressographs on each page and this process will be audited monthly.

2.7 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 26: Staffing</td>
<td>Low</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Low</td>
</tr>
<tr>
<td>Code of Practice on People working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Low</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge</td>
<td>Low</td>
</tr>
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</table>

The approved Centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.

2.8 Areas of compliance rated Excellent on this inspection

No areas were rated Excellent on this inspection.

2.9 Areas not applicable

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

| Regulation 17: Children’s Education | Regulation 30: Mental Health Tribunals |
| Rules Governing the Use of Electro-Convulsive Therapy | Rules Governing the Use of Seclusion |
| Part 4 of the Mental Health Act 2001 – Consent to Treatment | Code of Practice relating to the Admission of Children under the Mental Health Act 2001 |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients |

#### 2.10 Areas of good practice identified on this inspection

- Good information booklet available for residents and their families.
- Good information folder containing information for residents and families on medications and diagnoses.
- Staff engaged with residents in a caring, compassionate, dignified manner.
- Good evidence of multidisciplinary team involvement with residents, particularly in relation to individual care planning.
- Continual improvement planning for the service and St Anne’s unit.

#### 2.11 Reporting on the National Clinical Guidelines

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

#### 2.12 Section 26 Mental Health Act 2001 - Absence with Leave

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

#### 2.13 Resident Interviews

Residents were invited to speak with the inspection team on day three of the inspection. Three residents spoke briefly to the inspection team and the residents reported that “they were well looked after”, “staff were nice”, “happy here” and “food is good”.

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2.14 Resident Profile

<table>
<thead>
<tr>
<th></th>
<th>Less than 6 months</th>
<th>Longer than 6 months</th>
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<tbody>
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<td>Involuntary Patients</td>
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<td>Wards of Court</td>
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<td><strong>DAY 2</strong></td>
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</tr>
<tr>
<td>Voluntary Residents</td>
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<td>Involuntary Patients</td>
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<td>Wards of Court</td>
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2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. In attendance at the meeting were:

- Inspection team
- Executive Clinical Director
- Senior Social Worker
- Business Manager
- Head of Services
- Clinical Placement Coordinator
- Dietician
- Senior Clinical Psychologist
- Nurse Practice Development Coordinator
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Staff Nurse
- Clinical Nurse Manager 2
- Consultant Psychiatrist
- Acting Occupational Therapy Manager
- Locum Consultant Psychiatrist

The inspection team gave feedback on the Regulations, Rules and Codes of Practice inspected during the course of the inspection. Issues highlighted by the inspection team included fire safety, staffing, staff training and the discharge process of residents.
The inspection team heard from the senior management team with regards to the future plans to refurbish the unit with the view to making the shared bedrooms into single bedrooms. The management team also commented on their desire that the inspection report would highlights the positive work and care that occurs on St Anne’s Unit.
3.0 Inspection Findings and Required Actions - Regulations

<table>
<thead>
<tr>
<th>PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001</th>
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<tbody>
<tr>
<td>EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)</td>
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<th>3.1 Regulation 1: Citation</th>
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<th>3.2 Regulation 2: Commencement</th>
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<table>
<thead>
<tr>
<th>3.3 Regulation 3: Definitions</th>
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<tr>
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</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 written policy available in relation to the identification of residents in the approved centre. The policy included the roles and responsibilities in relation to the identification of residents, the required use of two resident identifiers prior to the administration of medications, therapies or other services. The policy also included the required use of two appropriate resident identifiers prior to medical investigations and the process of identification applied for same/similarly name residents was also included in the policy.

Training and Education: Not all members of staff had signed to indicate they had read and understood the policy. Staff could articulate the processes for the identification of residents.

Monitoring: An annual audit had been completed to ensure that there were appropriate resident identifiers on the clinical files. Analysis had been completed to identify opportunities to improve the resident identification process.

Evidence of Implementation: There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs. These included resident photograph, name, address, date of birth and Medical Record Number (MRN). An addressograph label was used on documentation. Identifiers used were person-specific and appropriate to the residents’ communication abilities. Two appropriate identifiers were used when administering medication and before providing therapies or other services. There was a red sticker alert system for same/similarly named residents.

The approved centre was assessed as Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

<table>
<thead>
<tr>
<th>Compliance with Regulation</th>
<th>Compliant</th>
<th>Non-Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>Satisfactory</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Quality Assessment</td>
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</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: The approved centre had a comprehensive policy in place which was updated in August 2016. The policy included roles and responsibilities in relation to providing food and nutrition for individual residents including the assessment of individual resident’s dietary needs and monitoring each resident’s food and fluid intake.

Training and Education: Not all staff had signed to say that they had read and understood the policy. Staff could articulate the policies and procedures in relation to providing food and nutrition in the approved centre.

Monitoring: The service wide Nutritional Steering Group had completed a review of the nutritional values of the current menu plans, including modified diets in the approved centre.

Evidence of Implementation: The approved centre had a four-weekly menu plan which varied the options from week to week. Residents had at least two choices of nutritious meal options at breakfast, lunch and teatime. Alternative meals were provided on request. Textured diets were well presented for those residents with special dietary needs.

Hot and cold drinks were offered at meal times, mid-morning and afternoon, and at other times throughout the day. The cold water dispenser was situated in the staff room due to the profile of the resident group. Water and juice from the dispenser was available to residents in line with their risk assessments.

The approved centre was in the process of introducing the St Andrews Nutritional Screening Tool (SANSI) in line with the current policy on Food and Nutrition. The assessment tool had been used to assess residents’ risk of nutritional problems and two residents had been referred to the dietetic service following assessment. All residents were weighed weekly and weights were recorded in each resident’s clinical file. Weight loss was discussed at a weekly MDT (multidisciplinary team) meeting and appropriate referrals were made to the dietetic service.

Clinical files documented the assessment of individual resident’s nutritional status on admission and subsequent monitoring and management of any risks including referrals to a dietician, reassessments and documented management plans.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.
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<tr>
<th>Compliance with Regulation</th>
<th>Compliant</th>
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<td>Excellent</td>
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3.6 Regulation 6: Food Safety

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

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

Inspection Findings

Processes: The approved centre had a comprehensive policy in place which was reviewed in October 2016. The policy covered roles and responsibilities in relation to food safety processes including food preparation, handling and storage of food and disposal of food waste. The policy also made reference to relevant Food Safety legislation and HACCP (Hazard Analysis Critical Control Points) training.

Training and Education: Not all staff had signed to say that they had read and understood the policy. Catering staff had up-to-date training in food safety including HACCP training. Staff were able to articulate the processes relating to food safety as outlined in the policy.

Monitoring: Food and fridge temperatures were recorded and records were up-to-date. Audits of kitchen cleaning schedules and temperature controls were made available for the inspection team. The Environmental Health report from September 2016 documented full compliance with food safety legislation.

Evidence of Implementation: The kitchen was clean and tidy. All cleaning schedules and temperature controls were recorded and were up-to-date. The kitchen had appropriate facilities for the storage and serving of food. Personal protective clothing was available for catering staff and nursing staff were wearing the same. There was sufficient crockery and cutlery to meet the residents’ needs.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

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<tr>
<th>Compliance with Regulation</th>
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<th>Non-Compliant</th>
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| Quality Assessment | Excellent | Satisfactory | Requires Improvement | Inadequate | X |
3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There was a written policy available in relation to residents’ clothing in the approved centre. The policy included the process and procedure to provide clothing to residents where necessary and the use of night and day clothes. The policy also included the process for recording the use of night clothes worn during the day in each resident’s individual care plan.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for residents’ clothing as set out in the policy.

Monitoring: Staff continuously monitored residents’ clothing needs. A record was kept of residents wearing night clothes during the day, however there were no residents wearing night attire during the day at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use their personal clothing. Residents clothing was observed to be clean and appropriate to their needs. Staff attended to residents’ laundry and staff also labelled residents’ clothing, as required. A supply of emergency clothing was stocked and funds for emergency clothing could be sourced from the social work department if required. All residents had an adequate supply of personal clothing. Each resident had a large wardrobe to store their clothing in.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

<table>
<thead>
<tr>
<th>Compliance with Regulation</th>
<th>Compliant</th>
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<table>
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<tr>
<th>Quality Assessment</th>
<th>Compliant</th>
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<tr>
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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 written policy available in relation to residents’ personal property and possessions in the approved centre. The policy included the processes and procedures regarding the roles and responsibilities to manage and support residents with their personal property and possessions. The policy also included the process to record, secure and manage the personal property and possessions of the resident, including money.

The policy did not specify communications with the resident, and their representatives, regarding the resident’s entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

The policy also did not specify the process to allow a resident access to, and control over, their personal property and possessions, unless it posed a danger to the resident, or others, as indicated following an individual risk assessment and the resident’s individual care plan.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for residents’ personal property and possessions as set out in the policy.

Monitoring: Personal property logs were maintained and monitored. Analysis had been completed to identify opportunities to improve the processes for residents’ personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safe-keeping of resident’s monies, valuables, personal property and possessions. There was a safe available in the clinical room which was maintained by the CNM2 (Clinical Nurse Manager 2) on duty. The approved centre maintained a property checklist for each resident and a copy of each resident’s personal property was given to the resident. A property log book detailing each resident’s personal property and possessions was maintained and kept in the office. This was kept separate to the resident’s individual care plan. Two nursing signatures were recorded on each entry where money belonging to the resident was handled by clinical
staff and receipts for expenditures were retained. Residents were supported to manage their own property, unless otherwise indicated.

A Corrective and Preventative Action Plan (CAPA) had been completed following the inspection in 2015 to address previous non-compliance.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Processes and Training and Education pillars.

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3.9 Regulation 9: Recreational Activities
The registered proprietor shall ensure that an Approved Centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

Inspection Findings

Processes: The approved centre had a policy in place for recreational activities. The policy met all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for the provision of recreational activities by the approved centre.

Monitoring: A record of the occurrence of planned recreational activities, including a record of resident uptake/attendance, was recorded in each resident’s clinical file. Analysis was completed by the activities nurse to identify opportunities to improve the processes for recreational activities.

Evidence of Implementation: The approved centre provided recreational activities appropriate to the resident group profile both on weekdays and at weekends. A recreational activities programme had been developed and maintained for the residents, with resident involvement. These included aromatherapy, scalp and hand massage, manicures, spa use, hairstyling and live music (the Art Squad visited weekly to play music for residents). Soft ball, dominos, and playing cards were also available to residents.

A mobile pet farm visited during Easter and plans were in place for a repeat visit. Individual risk assessments were completed as appropriate. An exercise bike was available to residents in the day room. Residents had access to a large tarmac garden and were regularly accompanied on walks in the garden (weather dependant). Information was provided to residents which included the types and frequency of appropriate, meaningful and purposeful recreational activities available within the approved centre. Student nurses recorded “My Life Story” with each resident and this incorporated resident’s views and preferences. Resident decisions to participate, or not, in activities was respected and documented in their clinical files.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

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Ref MHC – FRM – 001- Rev 1
Page 19 of 70
3.10 Regulation 10: Religion
The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

Inspection Findings

Processes: The approved centre had a comprehensive policy in place which included roles and responsibilities and the processes in the approved centre relating to ensuring that individual residents were facilitated to practice their faith as they wished. The policy was reviewed in October 2016.

Training and Education: Not all staff had signed to say that they had read and understood the policy. Staff were able to articulate the processes in place to support individual residents of different faiths to practice their faith whilst in receipt of care services and during their daily lives within the approved centre.

Monitoring: There was auditing of the monitoring process on religion.

Evidence of Implementation: During the inspection, staff were observed to demonstrate respect and empathy with residents who wanted to practice their faith. Residents were supported to attend mass on site or to listen to the mass on the TV loop from the main hospital site. A priest visited the unit weekly and Eucharistic ministers visited the unit twice-weekly to administer the blessed sacrament. Staff were aware of individual resident’s wishes in regard to religious practices. Information regarding multi-faith chaplains was available for residents from different religions.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgment Support Framework under the Training and Education pillar.

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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 policy relating to visits and there was a process for facilitating visitors to the approved centre, including children. There was also a process to identify staff and contractors who might visit the unit.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were aware of the policies and procedures for resident visits.

Monitoring: There was on going monitoring of the procedures in relation to visits as part of the day-to-day ward management. There was a visitor’s book at the entrance of the unit which facilitated identification of all visitors including contractors to the unit.

Evidence of Implementation: Visiting times were publicly displayed at point of entry to the unit. Discussions with nursing staff indicated that visiting times were flexible for residents’ visitors. A visitor room was available within the unit for both families and children which included a small selection of child-friendly materials and toys.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

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3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: There was a policy relating to communication. The policy identified circumstances where restrictions on communication could be imposed. The policy also included procedures to be used to facilitate communication by residents.

The policy did not include access to interpreter services or indicate the individual risk assessment requirements in relation to resident communication activities.

Training and Education: Not all staff had signed to indicate they had read and understood the policy on communication. Staff were aware of the policies and procedures relating to resident communication.

Monitoring: Resident communication needs/restrictions were continually monitored by treating clinical staff. There was no analysis completed to identify opportunities to improve communication processes.

Evidence of Implementation: Resident communication needs were assessed at point of admission initially and continually assessed thereafter. Residents were permitted to keep their mobile phones and staff facilitated residents to use the unit’s cordless phone to make and receive telephone calls as there was no public telephone on the unit. Residents received their own post directly, it was not subject to examination by staff.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Processes, Training and Education and Monitoring pillars.

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Ref MHC – FRM – 001- Rev 1

Page 22 of 70
### 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 policy in place relating to the carrying out of resident searches. The policy covered all the requirements outlined in the regulation, including the procedure in undertaking a search for illicit substances and carrying out searches with and without consent.

**Training and Education:** Not all staff had signed to indicate that they had read and understood the policy. Staff were able to articulate the processes involved in searches of a resident, their belongings and/or their environment.

As the approved centre had not carried out any resident searches since the last inspection they were assessed on the Processes and Training and Education pillars only and assessed as Compliant.

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3.14 Regulation 14: Care of the Dying

(1) The registered proprietor shall ensure that the Approved Centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident's death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident's death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the Approved Centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

Inspection Findings

Processes: The approved centre had two written policies in place that outlined protocols in relation to care of the dying in the approved centre. The policies included the majority of the requirements of the Judgement Support Framework with the exception of the following:

- The processes for advance directives in relation to end of life care, Do Not Attempt Resuscitation orders (DNARs)
- The process for ensuring that the approved centre was informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for end of life care.

Monitoring: Two deaths had occurred within the approved centre since the last inspection. End of life care was systematically reviewed. No analysis was completed to identify opportunities to improve the processes for the care for the dying.

Evidence of Implementation: The clinical files of two residents who had died were inspected. The end of life care provided was appropriate to both resident's physical, emotional, social, psychological and spiritual needs and this was documented in both residents' individual care plan. The privacy and dignity of the residents was protected during end of life care and the residents were accommodated in a single room within the approved centre. A Palliative Care Team was involved where necessary so that pain management was prioritised and managed. Family, next-of-kin and friends were involved, supported and accommodated during end of life care for both residents. No DNAR orders were in place. There was
documented evidence that the Mental Health Commission was notified within 48 hours of deaths within the approved centre.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Processes, Training and Education and Monitoring pillars.

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3.15 Regulation 15: Individual Care Plan
The registered proprietor shall ensure that each resident has an individual care plan.
[Definition of an individual care plan: “... a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation”.]

Inspection Findings

Processes: The approved centre had a policy in place that outlined its processes in relation to individual care plans. The policy met all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes relating to individual care planning as set out in the policy. There was no documented evidence that all multi-disciplinary team members were trained in individual care planning.

Monitoring: Individual care plans were audited on a quarterly basis. There was documented evidence of analysis completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: An initial care plan had been completed for each resident at the time of admission. An individual care plan was then developed by the MDT (multidisciplinary team), following a comprehensive assessment, within seven days.

All six resident’s care plans were reviewed. All six had initial care plans completed. There was evidence of family involvement in all care plans reviewed. An addendum in four of the six resident clinical files stated that the approved centre had agreed not to give residents a copy of their ICP (Individual Care Plan) due to capacity and confidentiality issues.

Resident needs were identified in all care plans. All care plans identified appropriate goals and interventions. All care plans identified the resources required to provide the care and treatment identified. A key worker was allocated to all residents. All of the reviewed care plans contained an individual risk management plan and a preliminary discharge plan.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

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3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: The approved centre had a policy in place that outlined its processes in relation to therapeutic services and programmes. The policy met all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for therapeutic services and programmes.

Monitoring: There was evidence of ongoing monitoring of the range of services and programmes provided. There was no documented evidence of analysis to identify opportunities to improve the processes for therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents. Programmes in the approved centre included butterfly moments, reminiscence therapy, beauty therapy, art therapy and doll therapy. The therapeutic services and programmes provided by the approved centre were evidence-based and individualised. A list of daily therapeutic activities available to residents were on the white board in the day room.

A record maintaining participation, engagement and outcomes achieved in therapeutic services or programmes was not available within the resident's individual care plans. An activities room and day room were available to provide therapeutic services and programmes. When a resident required a therapeutic service or programme that was not provided directly by the approved centre, arrangements were made to source that resource externally, by an approved qualified health professional. The approved centre did not maintain a record of resident participation in therapeutic services and programmes.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Training and Education, Monitoring and Evidence of Implementation pillars.

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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

The approved centre did not admit children, therefore, Regulation 17 Children’s Education was not applicable.
3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: There was a policy on transfer, which described the process for transferring a resident from the approved centre to another facility and outlined the various roles and responsibilities of staff in the process. The policy included information on the criteria for transfer, communication requirements and documentation requirements.

The policy did not outline the process for managing residents’ medication and personal property during the transfer process nor did it include the process for ensuring resident dignity and confidentiality during the transfer process.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for resident transfer.

Monitoring: The approved centre maintained a daily report log of resident information which included any resident who had been transferred. The approved centre had recently created a summary form which was completed in the event of a resident being transferred from the unit.

Evidence of Implementation: A clinical file was examined where a resident was transferred to another centre for medical reasons. The decision to transfer was justified and documented. The communication process was clear and included reasons for resident transfer, nurse accompaniment during the transfer process, risk assessment completion, clear involvement of the multidisciplinary team and interagency collaboration was evidenced. Full and complete written information regarding the resident transfer was captured using a transfer form and summary form.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Processes and Training and Education pillars.

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3.19 Regulation 19: General Health

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

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

Inspection Findings

Processes: The policy included all the requirements of the Judgement Support Framework including procedures for responding to medical emergencies with the exception of the following:

- Management, response and documentation of a medical emergency, including cardiac arrest and anaphylaxis.
- Staff training requirements in relation to Basic Life Support (BLS).
- The roles and responsibilities in relation to the provision of general health services to residents.
- Access to national screening programmes available for residents through the approved centre.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for responding to medical emergencies and the provision of general health services in the approved centre.

Monitoring: Resident take-up of national screening programmes was recorded and monitored in a Physical Health folder kept in the nurses’ office. A systematic review was undertaken to ensure six-monthly reviews of resident general health needs take place. There was evidence of analysis having been completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had a resuscitation tray and staff had access to an Automated External Defibrillator (AED). Weekly checks were completed and recorded. Records were available of any medical emergency that occurred within the approved centre and the care implemented.

A physical examination was carried out for each resident at admission and on an ongoing basis in line with the residents’ individual care plans. All residents had six-monthly physical examinations. There were opportunities for residents to pursue healthy lifestyle choices within the approved centre. Residents had access to national screening programmes that were available according to age and gender. A new cancer screening initiative for all residents had been incorporated since June 2016. Information leaflets were available as well as a folder in the office with information on the national screening programmes.
The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the *Judgement Support Framework* under the Processes and Training and Education pillars.

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3.20 Regulation 20: Provision of Information to Residents

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

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

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

Inspection Findings

Processes: The approved centre had a written policy covering procedures for the provision of information to residents. A comprehensive Resident Information Booklet was available which outlined a variety of housekeeping arrangements and advocacy arrangements.

The policy did not identify the residents' preferred ways of receiving and giving information or outline the process to manage the provision of information to residents' representatives, family and/or next of kin.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for the provision of information to residents.

Monitoring: Residents were provided with a Resident Information Booklet on admission to the unit detailing information about each resident's multi-disciplinary team MDT, housekeeping practices, information on medication and complaints. Analysis was completed by the approved centre to identify opportunities to improve the processes for providing information to residents. The nursing staff on the unit held resident meetings monthly which gave the residents an opportunity to discuss any issues concerning them and/or their care and treatment.

Evidence of Implementation: The Resident Information Booklet provided information to the residents on housekeeping practices, mealtimes, visiting times and advocacy arrangements. Information was provided to residents about their medication regimes and side effects. Residents had access to interpreter services. The approved centre had an Information Folder for residents and their families which contained comprehensive up-to-date information on advocacy, support for carers, statutory and voluntary organisations, caring for somebody with dementia, changed behaviours, dementia tips, common medications etc.

Residents and their families were provided with both verbal and written information regarding their diagnoses, including diagnosis-specific leaflets. Individual assessment of
Communication needs of the resident group formed the core of the care planning process. The capacity of the residents to understand the information given to them was also evidenced in the clinical files inspected.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the *Judgement Support Framework* under the Processes and Training and Education pillars.

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3.21 Regulation 21: Privacy
The registered proprietor shall ensure that the resident’s privacy and dignity is appropriately respected at all times.

Inspection Findings

Processes: The approved centre’s privacy policy, entitled Providing Privacy and Intimate Care, outlined that resident privacy and dignity was identified and assured throughout the resident’s stay in the approved centre specifically in relation to consent, physical care interventions, risk and health and safety issues.

The policy did not identify nor outline the process to be applied in the event where resident dignity and privacy was not respected by staff.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes for the provision of privacy to residents.

Monitoring: There was no evidence of monitoring of the process.

Evidence of Implementation: Residents were observed to be appropriately dressed in day clothes and were addressed by their first names. Staff were observed to knock before entering residents’ bedrooms. All bathrooms, showers and toilet doors were fitted with a lock on the inside to ensure privacy and these locks could be overridden by staff if required.

All residents’ bedrooms had curtains on the windows and around each bed to ensure privacy. Residents who required assistance with self-care, such as bathing and assistance at mealtimes, were observed to be treated in a respectful manner and with sufficient staff numbers to ensure dignity and respect. There was no confidential resident information on display either on public noticeboards or on noticeboards within the nurses’ station.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Processes, Training and Education and Monitoring pillars.

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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: The approved centre had a comprehensive policy on premises which included defined processes for managing the premises to ensure safety with due regard to the specific needs of the residents. There were processes in respect of premises, which included a maintenance programme for routine maintenance works. The policy also outlined the processes for maintaining a cleaning schedule and that infection control issues were managed by a designated infection control nurse. All staff were charged with the responsibility to notify their line manager of any defects or faults noticed with the premises or equipment.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were aware of the process for dealing with maintenance issues in the approved centre. Training in infection control was completed by a designated infection control nurse.

Monitoring: An infection control and ligature audit had been carried out. The approved centre had established the Mayo Mental Health Judgement Support Framework Working Group which had completed a comprehensive audit on premises. Feedback from the senior management team indicated that there were capital works pending to improve and modernise the unit, with the focus on the creation of a therapy and examination room, creation of appropriate toilet facilities for visitors and to modernise the dormitory bedrooms with the view to convert them into single bedrooms.

Evidence of Implementation: The premises was clean throughout. The interior of the unit was clean and brightly lit with a sufficient supply of fixtures and fittings appropriate to the
needs of the particular resident group accommodated there. All areas were wheelchair-accessible with ample assisted baths and showers. There was a designated sluice room and laundry room with adequate storage facilities available. Bathroom doors were fitted with locks, which could be overridden by staff, and there was a private room for residents’ families or visitors. There was no examination room available. The residents’ dining room was large and spacious and easily accommodated all residents in a single sitting during mealtimes. The communal area and residents’ day room was large with ample chairs and couches, large TV and fireplace. The unit was well heated and ventilated, had an adequate level of space for the residents, was furnished to a good standard with good indoor and outdoor spaces that residents could access and was in a good decorative appearance throughout.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Training and Education and Evidence of Implementation pillars.

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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: The approved centre had a policy outlining the roles and responsibilities in relation to the ordering, prescribing, storing and administration of medicines. The policy also contained information on the processes in relation to medication reconciliation, withholding medication, and refusal of medication, medication errors and “near miss” and adverse reactions of medications.

The policy did not contain information on the processes for crushing medication, reviewing resident medication and the process for medication management at point of resident admission, transfer and discharge.

Training and Education: Staff were able to articulate the processes as set out in the Medication Management Policy and the Management of Medication Fridges Policy. Not all staff had read and understood the policy relating to the ordering, storing, prescribing and administering of medication.

Monitoring: The approved centre had actively engaged in monthly audits of Medication Prescribing and Administration Records (MPARs), to ensure compliance with the policy, regulations, applicable legislation and guidelines. The Mayo Mental Health Service Drugs and Therapeutic Committee was actively involved in identifying and improving medication management processes in terms of audit and medication reconciliation. The pharmacist met with residents receiving Lithium therapy.

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 MPAR’s in use in the unit were assessed on inspection. Generic medication names and the prescribers’ signatures and Medical Council Registration Numbers (MCRNs) were present in all medication charts. Controlled drugs were stored securely in a locked press and two nurses signed for the administration of a controlled drug. There was a fridge in the clinical room which was only used for storing medication and an adequate log was maintained of fridge temperature.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Processes and Training and Education pillars.
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3.24 Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an Approved Centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

Inspection Findings

Processes: The approved centre had a comprehensive health and safety policy and relevant guidance documents including a risk management policy, a health and safety statement and a risk register. There were also fire safety procedures and infection control guidance documents. Documents were up-to-date and reflected relevant legislation. The health and safety policy included roles and responsibilities to ensure that mandatory training was kept up-to-date.

Training and Education: Not all staff had signed to say that they had read and understood the policy. All relevant staff were trained in moving and handling and Professional Management of Aggression and Violence (PMAV) however, not all staff were trained in Basic Life Support (BLS) and fire safety. Staff could articulate the relevant policies and procedures in relation to health and safety processes in their areas of work including fire safety and responding to emergencies.

Monitoring: A health and safety audit had been completed in August 2016. An improvement action plan had been put into place and partly implemented at the time of the inspection.

Evidence of Implementation: Staff demonstrated adherence to health and safety processes in their day-to-day work. Staff were observed to manage an emergency call in a calm and effective manner during the inspection.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under Training and Education pillar.

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### 3.25 Regulation 25: Use of Closed Circuit Television

1. The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

   a. It shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

   b. It shall be clearly labelled and be evident;

   c. The Approved Centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

   d. It shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

   e. It must not be used if a resident starts to act in a way which compromises his or her dignity.

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

3. The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the Approved Centre or at anytime on request.

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#### Inspection Findings

CCTV was not in use within the approved centre, therefore, this regulation not applicable.

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3.26 Regulation 26: Staffing

(1) The registered proprietor shall ensure that the Approved Centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the Approved Centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the Approved Centre at all times and a record thereof maintained in the Approved Centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the Approved Centre.

Inspection Findings

Processes: The approved centre had a comprehensive written operational policy on the recruitment, selection and vetting of staff. The policy outlined the lines of management in place within the approved 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. The policy did not contain job description requirements.

Training and Education: Staff were able to articulate the processes relating to staffing as set out in the policy. Not all staff had read and understood the policy in relation to staffing.

Monitoring: The Clinical Nurse Manager 3 (CNM3) on the unit monitored and implemented the training plan and programme of training for staff and this was regularly reviewed to ensure that staff were facilitated to attend mandatory training as well as additional in service training. The number and skill mix of staff was reviewed against the levels recorded in the approved centre’s registration. The approved centre had recently updated and improved their staffing policy in response to Mental Health Commission feedback from other approved centres within the Mayo Mental Health Service umbrella, as well as guidance from the Judgement Support Framework.

Evidence of Implementation: At the time of inspection, the approved centre contained the following numbers and skill mix of staff, including:

- Consultant Psychiatrist x 2
- Senior Registrar x 1
- Registrars x 2
- Occupational Therapist x 1
- Social Worker x 1
- Psychologist x 1
- Clinical Nurse Manager 3 x .5 WTE
- Clinical Nurse Manager 2 x 3
Nursing Staff x 11  
Activities Nurse x .6 WTE  
Health Care Assistants x 6  
Multi-Task Attendants x 7

Two Multidisciplinary teams worked in the approved centre.

The approved centre had an organisational chart of the Area Management Team and an organisational chart of St Anne’s Unit outlining the lines of leadership and management structures within Mayo Mental Health Service. There was a written staffing plan for St Anne’s Unit which was updated as required. The staffing plan took into consideration the assessed needs of the resident group.

The service had undertaken a Training Needs Analysis and Training Plan for Approved Centres in Mayo Mental Health Service (including St Anne’s Unit) which identified annually the required training and skills development in line with the assessed needs of the resident profile within the unit. All staff training was documented and was available to the inspection team. The St Anne’s Unit Training Folder, at time of inspection, indicated that the relevant healthcare professionals had completed:

Fire Safety – 81%  
Mental Health Act Training – 100%  
Professional Management of Aggression and Violence Training (PMAV) – 100%  
Basic Life Support – 78%

The approved centre was non-compliant with Regulation 26(4) Staffing, as not all healthcare professionals attached to the unit had completed mandatory training in Basic Life Support and Fire Safety.

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

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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 policy included the majority of the requirements of the Judgement Support Framework with the exception of the following:

- Reference to retention of inspection reports relating to food safety, health and safety and fire inspections
- The process for making a retrospective entry in residents’ records.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff could articulate the processes in relation to the creation of, access to, retention of and destruction of records. All clinical staff were trained in best-practice record keeping commensurate with their professional roles and induction training.

Monitoring: Resident records were audited to ensure their completeness, accuracy and ease of retrieval. There was evidence that analysis had been completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: All residents’ clinical files were up-to-date, in good order and in accordance with relevant legislation. Records were kept in a filing cabinet in the locked nurses’ office. Each resident had an individual clinical file with unique identifiers as required. The records had been developed and maintained in a logical sequence. Only authorised staff made entries in the residents’ clinical files. The entries in four records were written in blue ink. Errors were crossed out but not dated or initialled. All clinical files had a signature with entries made by student nurses’ countersigned by a registered nurse. No loose pages were found in clinical files. Resident records were developed and maintained in a logical sequence.

The most recent Fire Inspection and Environmental Health Officer’s reports were made available to the inspection team.

A Corrective and Preventative Action Plan (CAPA) had been completed following the inspection in 2015 to address the area of non-compliance.
The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the *Judgement Support Framework* under Processes, Training and Education and Evidence of Implementation pillars.

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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

Processes: The approved centre had a policy in place which was reviewed in June 2016. The policy included roles and responsibilities and the processes in place to maintain and update the register in the format determined by the Mental Health Commission.

Training and Education: Not all staff had signed to indicate they had read and understood the policy. Staff were able to articulate the processes involved in maintaining and updating the register of residents.

Monitoring: The current register was up-to-date.

Evidence of Implementation: The current register was up-to-date and included all the residents in the approved centre. The register did not include diagnosis on admission nor diagnosis upon discharge as required in the regulation and as a result the approved centre was found to be Non-Compliant with Regulation 28.

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3.29 Regulation 29: Operating Policies and Procedures

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

Inspection Findings

Processes: The approved centre had a comprehensive policy in place which was reviewed in April 2016. The policy included all requirements of the Judgement Support Framework. The approved centres’ policies were developed through the Mayo Mental Health Services Policy, Procedure and Guidelines [PPPG] management group which met quarterly and had appropriate representation as defined in the policy.

Training and Education: Not all staff had signed to say that they had read and understood the policy. Staff were able to articulate their roles and responsibilities in relation to operating policies and procedures.

Monitoring: The Mayo Mental Health Service carried out an audit of the processes relating to operating policies and procedures in June 2016.

Evidence of Implementation: All policies and guidance documents were reviewed in line with Mayo Mental Health Services policy on Operating Policies and Procedures. Once a policy had been reviewed and approved through the PPPG management group it was disseminated via the approved centre’s pulse system and staff could access it via email. All staff had access to the email system. Staff training and updates included relevant policy revisions.

The approved centre was assessed as compliant Satisfactory for this regulation as it did not meet all the requirements of the Judgement Support Framework under the Training and Education pillar.

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### 3.30 Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an Approved Centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the Approved Centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the Approved Centre.

### Inspection Findings

As there were no detained patients in the approved centre at the time of inspection, this regulation did not apply.
3.31 Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an Approved Centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an Approved Centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the Approved Centre.

(4) The registered proprietor shall ensure that a nominated person is available in an Approved Centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the Approved Centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

Inspection Findings

Processes: The approved centre had a comprehensive complaints policy which was entitled “Feedback policy” which was implemented in January 2015. The policy included the HSE Your Service Your Say guidance.

Training and Education: Not all staff had signed to say that they had read and understood the policy. Relevant staff were trained in the complaints processes. All staff interviewed were able to articulate the processes involved in making and receiving feedback and complaints as defined in the approved centre’s policy.

Monitoring: All complaints were monitored by the senior management team. Quarterly audits were completed and audit reports were fed back to the approved centre.

Evidence of Implementation: The nominated person responsible for handling complaints was clearly displayed for residents and their families, however their contacts details were not available. A complaints procedure flow chart outlining the procedures for residents or their families on how to make a complaint was displayed. Your Service Your Say leaflets were available to residents and the procedures for making complaints was also addressed in the Resident Information Booklet. The approved centre’s complaints log was inspected and complaints were recorded and managed appropriately. A record of the outcome of complaints was documented. Information about advocacy services were available for the residents and their families.

The approved centre was assessed as compliant Satisfactory as it did not meet all the requirements of the Judgment Support Framework under the Training and Education and Evidence of Implementation pillars.
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3.32 Regulation 32: Risk Management Procedures

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

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

(a) The identification and assessment of risks throughout the Approved Centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
(i) resident absent without leave,
(ii) suicide and self harm,
(iii) assault,
(iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

Inspection Findings

Processes: The approved centre had a comprehensive risk management policy in place which included the identification and assessment of risks throughout the approved centre, the precautions in place to control risks identified including resident absent without leave, suicide and self-harm, assault and accidental injury to residents and staff. The policy also included the arrangements for the identification, recording, investigating and learning from serious or untoward incidents involving residents.

The policy did not include the processes in place for:

- Maintaining and reviewing the risk register
- The named person responsible for producing the six-monthly incident reports for the Mental Health Commission (MHC).

The approved centre had a separate policy on responding to emergencies and had a documented emergency plan in place.

The approved centre used the HSE guidance on Children First and the Protection of Vulnerable Adults.

Training and Education: Not all staff had signed to say that they had read and understood the risk management policy. Nursing staff were trained in risk management and incident reporting processes. Staff demonstrated awareness of their roles and responsibilities in relation to risk management and incident reporting. The approved centre’s Clinical Nurse
Manager 2 and Clinical Nurse Manager 3 had also completed training on health and safety and risk management.

**Monitoring:** There was an up-to-date risk register in place and all incidents were reported and audited on a three-monthly basis. Analysis of serious incidents and adverse events was carried out by the senior management team in line with the approved centre’s written policies.

**Evidence of Implementation:** There was a nominated risk manager for the approved centre. Individual residents had risk assessments carried out as part of their initial assessments and ongoing care plan reviews. Residents and their families were involved in the individual risk management plans as part of the resident’s care planning process.

All incidents were reported and risk rated. Incidents were reviewed by the multi-disciplinary team and individual care plans were reviewed appropriately. Incidents were reported to the senior management team and escalated appropriately. Analysis of serious incidents and adverse events was carried out by the senior management team in line with the approved centre’s written policies.

The approved centre was assessed as compliant Satisfactory as it did not meet all the requirements of the Judgement Support Framework under Processes and Training and Education pillars.

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<thead>
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### 3.33 Regulation 33: Insurance

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

#### Inspection Findings

The approved centre had insurance cover provided to the HSE by the State Claims Agency. It covered public liability, employer’s liability, clinical indemnity and property.

The approved centre was Compliant with this regulation.

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<thead>
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<th>Compliance with Regulation</th>
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3.34 Regulation 34: Certificate of Registration

The registered proprietor shall ensure that the Approved Centre’s current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the Approved Centre.

Inspection Findings

There was an up-to-date certification of registration displayed prominently in the approved centre located at the nursing station.

The approved centre was Compliant with this regulation.

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<thead>
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<th>Compliance with Regulation</th>
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</table>
## 4.0 Inspection Findings and Required Actions - Rules

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<tr>
<th>EVIDENCE OF COMPLIANCE WITH RULES – MENTAL HEALTH ACT 2001 SECTION 52(d)</th>
</tr>
</thead>
</table>

### 4.1 Section 59: The Use of Electro-Convulsive Therapy

Section 59

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

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

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

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

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

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

### Inspection Findings

No patient in the approved centre was receiving Electro-Convulsive Therapy (ECT) and there were no facilities for providing ECT on site. Therefore, this Rule was not applicable.
4.2 Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion

Section 69

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

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

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

(4) In this section “patient” includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient”.

Inspection Findings

As Seclusion was not used in the approved centre, this Rule was not applicable.
4.3 Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

(4) In this section “patient” includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient”.

Inspection Findings

Processes: There was a written policy available in relation to the use of mechanical restraint (Part 5) in the approved centre which was reviewed on an annual basis. The policy specified the required frequency of training and identified appropriately qualified staff to provide the training.

Training and Education: There were no specific training records regarding the use of mechanical restraint. Not all staff had completed the Professional Management of Aggression and Violence (PMAV) training.

Evidence of Implementation: One episode of mechanical restraint was reviewed. The reason for the use of mechanical restraint was due to the risk of harm to the resident themselves. The prescription on the use of mechanical restraint had been in consultation with the resident and their families and identified in resident’s individual care plan. The clinical file of the resident who had been mechanically restrained contained a record indicating the following:

- There was an enduring risk of harm to self or others.
- Least restrictive alternatives were implemented without success.
- The type of mechanical restraint.
- The situation where mechanical restraint was used.
- The duration of restraint.
- The duration of the order (in this case it was one month).
- The review date.

The approved centre was compliant with this rule.

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<th>Compliance with Rule</th>
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5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 Part 4: Consent to Treatment

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

(a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

(b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

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

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

(a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

(b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

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

Inspection Findings

As there were no detained patients in the approved centre, Part 4 of the Mental Health Act was not-applicable.
6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: The approved centre had a policy in place in relation to the use of physical restraint. The policy was reviewed on an annual basis and outlined the staff with the authority to initiate and carry out the physical restraint of a resident. The policy also outlined the training for staff and the information to be provided to the resident.

Training and Education: The training record showed that staff had received training in the Professional Management of Aggression and Violence (PMAV) with the inclusion of de-escalation techniques training in the approved centre and this training was ongoing. The approved centre’s signature log indicated that staff had read and understood the policy relating to the use of physical restraint.

Monitoring: The service had conducted regular audits on the use of physical restraint within the approved centre.

Evidence of Implementation: The clinical file of a resident who had been physically restrained in the approved centre was reviewed. The restraint episode was clearly recorded in the resident’s clinical file and was of the shortest duration possible. There was evidence that physical restraint had been used to prevent injury to self and others and the order had been initiated by a registered nurse. There was evidence that gender sensitivity was observed. The resident was risk-assessed in relation to physical restraint. The order for physical restraint was correctly completed and included the designated staff member who led the restraint. It was documented that the resident’s next of kin was informed. There was evidence that the resident had been reviewed by their consultant psychiatrist within
appropriate timeframes and that there was relevant documentation of multi-disciplinary team involvement in the discussion of physical restraint with the resident.

The approved centre was Compliant with the Code of Practice on the use of Physical Restraint.

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<th>Compliance with Code of Practice</th>
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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

The approved centre did not admit children and therefore, this Code of Practice was not applicable to the centre.
### 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 and Incident Reporting and written procedures in place for the notification of deaths and incidents to the Mental Health Commission.

**Training and Education:** Not all staff had signed to say that they had read and understood the relevant policies. Staff were able to articulate the processes involved in notifying deaths and incidents to the relevant authorities.

**Monitoring:** All incidents were reported and audited on a three-monthly basis. Analysis of serious incidents and adverse events including deaths was carried out by the senior management team in line with the approved centre’s written policies.

**Evidence of Implementation:** Two deaths had occurred since the last inspection and both were reported to the Mental Health Commission within the timescale required. Six-monthly summary incident reports were submitted to the Mental Health Commission as required by the Code of Practice on the notification of deaths and incidents.

The approved centre was assessed as Compliant with the Code of Practice on the notification of deaths and incidents.

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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 the care and treatment of persons with an intellectual disability in the approved centre. The policy reflected person-centred treatment planning, presumption of capacity and least restrictive interventions. The policy included the roles and responsibilities of staff, the management of problem behaviours, who should receive training in working with people with intellectual disability and identifying appropriately qualified people to give training. The policy did not include reference to induction training for new staff, areas to be addressed in training, frequency of training or evaluation of training programmes in working with people with intellectual disability.

*Training and Education:* Nineteen staff had completed training on the care and treatment of a person with an intellectual disability. All staff had up-to-date training in the Professional Management of Aggression and Violence (PMAV).

*Monitoring:* The policy had been reviewed three yearly as required.

There were no persons with an intellectual disability in the approved centre at the time of inspection.

The approved centre was Non-Compliant with this Code of Practice as there was no provision in the policy for:

(a) Induction training for new staff, areas to be addressed in training, frequency of training or evaluation of training programmes (6.2).

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**Risk Rating**

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</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.

Inspection Findings

No resident in the approved centre was receiving Electro-Convulsive Therapy (ECT) and there were no facilities for providing ECT on site. Therefore, this Code of Practice was not applicable.
6.6 Admission, Transfer and Discharge

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

Inspection Findings

Processes: Admission: There were policies on admission, transfer and discharge which applied to the approved centre as part of Mayo Mental Health Services. The admission policy identified the process for admission of voluntary and involuntary patients, urgent referrals and self-presentation.

The admission policy did not indicate the roles and responsibilities of multi-disciplinary team staff in relation to assessment after admission or identify communication with primary care and community mental health teams.

Transfer: The transfer policy described the process for transferring a resident from the approved centre to another facility and outlined the various roles and responsibilities of staff in the process. The policy included information on the criteria for transfer, communication requirements and documentation requirements. The policy included the provision of resident transfer abroad.

Discharge: The policy on discharge addressed the process for discharge against medical advice and procedures for discharge of involuntary patients. The policy also outlined the protocols for discharging homeless people or older persons and made reference to prescriptions and supply of resident medication on discharge.

The discharge policy did not include reference to relapse prevention strategies, crisis management plans, follow up care and contact and ways of following up and managing missed appointments.

Training and Education: Staff were aware of the processes involved in the admission, transfer and discharge of residents and there was documentary evidence available indicating that staff had read the policies on admission, transfer and discharge.

Monitoring: Monitoring of compliance with the processes had not taken place.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was reviewed. The resident’s admission was planned and there was a copy of the referral letter in the clinical file. The decision to admit was clearly documented. The resident had a comprehensive admission assessment that included current mental state, risk assessment, presenting problems, psychiatric history, family history, medical history, medication on admission, social history and a physical examination. The resident received the approved centre’s information booklet on admission and was allocated a keyworker. An individual care plan was developed with evidence of multi-disciplinary team involvement. The residents’ personal property was checked on admission and a checklist was maintained in the clinical file separate to the resident’s individual care plan.

Transfer: The clinical file of one resident that was transferred to another centre for medical reasons was examined. The decision to transfer was justified and documented. The communication process was clear, including reasons for resident transfer and nurse
accompaniment during the transfer process. A risk assessment was completed and there was evidence of multidisciplinary team involvement and interagency collaboration. Full and complete written information regarding the resident transfer was completed using a transfer form and summary form.

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed. The decision to discharge the resident was clearly planned and documented. The resident and their family were involved in the discharge process. A discharge meeting with the resident, their keyworker and the multi-disciplinary team took place. A follow-up appointment was given to the resident on discharge. The resident’s property and valuables had been returned to them upon discharge.

The approved centre was Non-Compliant with the Code of Practice on Admission, Transfer and Discharge as

(a) The admission policy did not indicate the roles and responsibilities of multi-disciplinary team staff in relation to assessment after admission (4.7)
(b) The admission policy did not identify communication with primary care and community mental health teams (4.9).
(c) The discharge policy did not include reference to relapse prevention strategies, crisis management plans, follow up care and contact and ways of following up and managing missed appointments (4.14).

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

Completed by approved centre:  St Anne’s Unit, Sacred Heath Hospital  
Date submitted:  10th March 2017

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

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.
Regulation 26: Staffing (inspection report reference 2.26)

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/ Realistic</th>
<th>Time-bound</th>
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<tbody>
<tr>
<td></td>
<td>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</td>
<td>Define the method of monitoring the implementation of the action(s)</td>
<td>State the feasibility of the action(s) (i.e. barriers to implementation)</td>
<td>Define time-frame for implementation of the action(s)</td>
</tr>
<tr>
<td>1. Not all healthcare professionals attached to the unit had completed mandatory training in Basic Life Support and Fire Safety.</td>
<td>Corrective action(s): Training Plan developed Post-holder(s): Practice Development Staff Preventative action(s): Continue monitoring &amp; evaluating training plan to optimise numbers trained. Post-holder(s): CNM2/3 &amp; head of disciplines.</td>
<td></td>
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<td>completed Monthly evaluation</td>
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### Regulation 28: Register of Residents (inspection report reference 3.28)

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<th>Area(s) of non-compliance</th>
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<th>Measurable</th>
<th>Achievable/ Realistic</th>
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<td><strong>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</strong></td>
<td><strong>Define the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>State the feasibility of the action(s) (i.e. barriers to implementation)</strong></td>
<td><strong>Define time-frame for implementation of the action(s)</strong></td>
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</table>

2. The register did not include diagnosis on admission nor diagnosis upon discharge as required in the regulation.

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<thead>
<tr>
<th>Corrective action(s):</th>
<th>Preventative action(s):</th>
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<tbody>
<tr>
<td>Register format amended to include diagnoses</td>
<td>CNM3 to monitor</td>
</tr>
<tr>
<td>Post-holder(s):</td>
<td>Post-holder(s):CNM3</td>
</tr>
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</table>

**Post-holder(s): completed**

**Preventative action(s): monthly**
### Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities (inspection report reference 6.4)

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<th>Area(s) of non-compliance</th>
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<th>Measurable</th>
<th>Achievable/ Realistic</th>
<th>Time-bound</th>
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<tr>
<td></td>
<td>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</td>
<td>Define the method of monitoring the implementation of the action(s)</td>
<td>State the feasibility of the action(s) (i.e. barriers to implementation)</td>
<td>Define time-frame for implementation of the action(s)</td>
</tr>
<tr>
<td>3. There was no provision in the policy for induction training for new staff, areas to be addressed in training, frequency of training or evaluation of training programmes.</td>
<td>Corrective action(s): Policy to be updated Post-holder(s): Policy Group</td>
<td>CNM3 will liaise with Policy group rep.</td>
<td></td>
<td>May 2017</td>
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<td></td>
<td>Preventative action(s): Contents of policy to be communicated to staff at next staff meeting and follow up with e-mail communication Post-holder(s): CNM2’s</td>
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<td></td>
<td>May 2017</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/ Realistic</td>
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<td>Define corrective and preventative action(s) to address the non-compliant finding and post-holder(s) responsible for implementation of the action(s)</td>
<td>Define the method of monitoring the implementation of the action(s)</td>
<td>State the feasibility of the action(s) (i.e. barriers to implementation)</td>
<td>Define time-frame for implementation of the action(s)</td>
</tr>
<tr>
<td>4. Admission policy did not meet the requirements of 4.7 and 4.9 of the code of practice.</td>
<td>Corrective action(s): New policy available for all staff Post-holder(s): Policy committee</td>
<td>Preventative action(s): To be communicated to all staff Post-holder(s): Policy committee</td>
<td>May 2017</td>
<td></td>
</tr>
<tr>
<td>5. Transfer policy did not meet the requirements of 4.13 (transfer abroad) of the code of practice.</td>
<td>Corrective action(s): As above Post-holder(s): as above</td>
<td>Preventative action(s): As above Post-holder(s): as above</td>
<td>May 2017</td>
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<tr>
<td>6. Discharge policy did not meet the requirements of 4.14 of the code of practice.</td>
<td>Corrective action(s): As above Post-holder(s): as above</td>
<td>Preventative action(s): As above Post-holder(s): as above</td>
<td>May 2017</td>
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