Acute Psychiatric Unit, Cavan General Hospital

**ID Number:** AC0019

**2017 Approved Centre Inspection Report (Mental Health Act 2001)**

<table>
<thead>
<tr>
<th>Approved Centre Type:</th>
<th>Most Recent Registration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Adult Mental Health Care</td>
<td>01 March 2017</td>
</tr>
<tr>
<td>Psychiatry of Later Life</td>
<td></td>
</tr>
<tr>
<td>Mental Health Care for People with an Intellectual Disability</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Conditions Attached:</th>
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<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Registered Proprietor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSE</td>
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</tbody>
</table>

**Registered Proprietor Nominee:**

Teresa Dykes, Operations Manager Mental Health, CHO 1

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**Inspection Team:**

Barbara Morrissey, Lead Inspector
Leon Donovan
Marianne Griffiths
Donal O’Gorman

**Inspection Date:**

18 – 21 April 2017

**Previous Inspection Date:**

16 – 18 August 2016

**Inspection Type:**

Unannounced Annual Inspection

**Date of Publication:**

14 September 2017

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**COMPLIANCE RATINGS 2017**

- **REGULATIONS**
  - Compliant: 24
  - Non-compliant: 1
  - Not applicable: 5

- **RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001**
  - Compliant: 1
  - Non-compliant: 3
  - Not applicable: 1

- **CODES OF PRACTICE**
  - Compliant: 1
  - Non-compliant: 4
  - Not applicable: 1
RATINGS SUMMARY 2015 – 2017

Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2015 – 2017
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1.0 Introduction to the Inspection Process

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

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

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

Inspector of Mental Health Services

Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated Judgement Support Framework, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

Safety in the approved centre

There was a written safety statement incorporating a safety policy. The approved centre had a designated patient quality and safety risk manager. Clinical risks and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Ligature points had not been minimised; and a ligature audit had not been done since 2014. Work to address structural risks, including ligature points, was ongoing.

At least two person-specific resident identifiers were used in the approved centre. There was documented evidence that food safety audits had been completed. Hygiene was maintained to support food safety, and the kitchenette and associated equipment were clean. In one case, there was no documentation of a risk assessment having taken place before physical restraint was used.

The start and discontinuation dates and the frequency of administration of medication were not recorded on all medication records. Out-of-date medication was found in one of the medication fridges and medication fridges were not clean. Not all staff had up-to-date, mandatory training in Basic Life Support, the management of violence and aggression, fire safety training, and Mental Health Act 2001. Staff were trained in accordance with the assessed needs of residents, and courses had been delivered in Children First, elder abuse, manual handling, medication management, hand hygiene, Trust in Care, care for residents with an intellectual disability, risk assessment, assisted admissions, preceptor training, and Electro-Convulsive Therapy.

Residents interviewed stated that they felt safe in the approved centre.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.
Appropriate care and treatment of residents

All residents had an individual care plan, which met the requirements of the relevant regulation. A new therapeutic programme development committee had been established and there was a wide range of available, evidence-based programmes appropriate to the assessed needs of the residents and outlined in their individual care plans. Programmes were provided by the occupational therapist and nursing staff, with input from the art therapist. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, and separate, dedicated rooms were available for their delivery.

Residents’ physical health was assessed on admission and their general health needs were monitored and assessed at least every six months. Residents could access general health services. Residents’ records were stored in locked filing cabinets in a locked room, and clinical files were up to date and in good order. The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment. The use of physical restraint was not compliant with the relevant code of practice. There had been one admission of a child since the previous inspection in 2016. Age-appropriate facilities and activities were not provided and the special requirements of the child in an adult setting were not addressed. The child’s right to have his/her views heard was not documented. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were not available in the approved centre.

Although the policies for admission, transfer and discharge were not adequate, implementation of the processes was good. The policy for caring for people with intellectual disability did not meet the code of practice.

RESPECT FOR RESIDENTS’ PRIVACY AND DIGNITY

Residents’ clothing was observed to be clean and appropriate to their needs. All residents had an adequate supply of individualised clothing. Residents were supported to manage their own property, and personal property and valuables were secured. Two members of staff or one member of staff and the resident or representative oversaw the process of providing residents with access to their monies. Signed records of staff issuing money were retained and countersigned by the resident or their representative. Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors with an override facility. In shared rooms, adequate and suitable privacy screening was in place around the beds. Not all observation panels on doors were appropriately screened. An observation room between male and female dormitories allowed residents to see into either room, which compromised privacy. Observation panel levers in two unoccupied rooms were broken and stuck in open and partially open positions. Seclusion was not used in the approved centre.

 AREAS REFERRED TO
Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.
Responsiveness to residents’ needs

A new discharge booklet and discharge packs for service users was available. Voluntary agencies were visiting the unit monthly (GROW and SHINE). Residents in the approved centre were provided with a range of wholesome and nutritious food choices, which were presented in an appealing manner. The needs of residents identified as having special nutritional requirements were not reviewed by a dietitian, and residents did not have formal or regular access to a dietitian. Residents had access to appropriate recreational activities, and a weekly timetable of activities was displayed. Recreational activities were scheduled on weekdays and at weekends. Residents provided input into the activities schedule at weekly meetings, and they had access to indoor and outdoor exercise and physical activity. A new self-esteem programme for service users had been developed.

Residents were facilitated in the practice of their religion. There was an oratory in the nearby general hospital, and residents had access to multi-faith chaplains when required. Visiting times, which were appropriate and reasonable, were publicly displayed at the entrance and in an information leaflet and visitors’ rooms were available. The family room, which had en suite toilet facilities and a selection of toys, was comfortably furnished and suitable for visiting children. Residents had access to external communications, including post, fax, e-mail, and Internet and could keep their own mobile phones. Information about the approved centre for residents was provided in a booklet and they were given written information about their diagnosis and medication.

The approved centre was in a reasonable state of repair, but issues such as stained tiles and damaged internal walls and floor tiles were observed during the inspection. There was no structured programme of general or decorative maintenance. A cleaning schedule was implemented for five hours per day, and the approved centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed. There was a nominated complaints officer in the approved centre. The approved centre’s management of complaints was well publicised and accessible. A review of five complaints lodged since the 2016 inspection found inadequate documentation of complaints. Details of the complaints and of subsequent investigations and outcomes were not fully recorded and there was no evidence that complainants were informed promptly of the outcome of the investigation or provided with details of the appeals process. Complainants’ satisfaction/dissatisfaction with the investigation findings was not recorded.

AREAS REFERRED TO
Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.
Governance of the approved centre

There was an organisational chart and clear governance structures and processes in place. The clinical governance structure encompassed the wider Cavan, Monaghan Mental Health Service. Patient quality and safety meetings reviewed the risk registers and infection prevention and control. There was service user representation at the business meetings and the patient quality and safety meetings. An appropriately qualified staff member was on duty and in charge at all times in the approved centre. Operating policies and procedures were developed with input from both clinical and managerial staff and in consultation with relevant stakeholders and were appropriately approved and communicated to all relevant staff. All operating policies and procedures mandated by the regulations were reviewed within the required three-year time frame.

AREAS REFERRED TO
Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.
The following quality initiatives were identified on this inspection:

- Service user representation was present at the monthly business meetings.
- A clinical nurse manager 2 out-of-hours service had been established for the A&E department.
- A new therapeutic programme development committee had been established.
- A new discharge planning committee has been established.
- A new discharge booklet and discharge packs for service users were available.
- Five registered mental health nurses had been trained to facilitate the Wellness Recovery Action Plan.
- Voluntary agencies were visiting the unit monthly (GROW and SHINE).
- A new self-esteem programme for service users had been developed.
- Smoking cessation was to be offered to residents. Intervention in this regard was to be included in their individual care plans,
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Acute Psychiatric Unit, which was well signposted, was located on the ground floor of Cavan General Hospital. The entrance doors were locked and access was via a swipe or by staff releasing the electronic door mechanism. There were eight consultant-led teams, two of which were for Psychiatry of Later Life, and there was one consultant-led in-house team. The approved centre was registered for 25 residents and had a catchment area of the counties Cavan and Monaghan.

The approved centre had three four-bed rooms, one six-bed room, and seven single en suite rooms. The approved centre was clean and bright at the time of the inspection. Residents had access to a central garden within the approved centre. There was also a family visiting room and a separate visiting room. Furnishings were comfortable throughout the unit. There was an information screen in the dining area, which provided ongoing information on services to residents. Residents had access to an Internet station. The general hospital had a shop/newsagent and a large canteen, which residents and staff from the approved centre could use. One resident was on section 26 leave at the time of the inspection.

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>25</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>11</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>5</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>0</td>
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<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>1</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

**Condition 1:** To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all health care professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 2:** The Mental Health Commission requires notification in writing when a programme of Electro-Convulsive Therapy (ECT) is prescribed for a patient or resident by the responsible consultant psychiatrist. The notification must be made prior to the administration of this programme and must include the following:

1. The proposed date of commencement of the programme of ECT.
II. Confirmation that the requirements of Section 10: Staffing of the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, as applicable, will be fully complied with throughout the administration of the programmed of ECT.

III. Confirmation that all staff members who will be involved in the administration of the programmes of ECT have completed an induction programme.

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre had an organisational chart and clear governance structures and processes in place. The clinical governance structure encompassed the wider Cavan, Monaghan Mental Health Service. Minutes from the monthly business meetings and the patient quality safety meetings indicated a robust and an active agenda with outcomes. Issues relevant to the approved centre were discussed and there was evidence of an ongoing commitment to quality improvement. The reintroduction of Electro-Convulsive Therapy had been debated at the business meetings. Policies for Electro-Convulsive Therapy were being updated and training for staff was being secured. Staff training and the review of training plans were also on the agenda. Auditing in relation to individual care plans was reviewed. Complaints was a standing item on the agenda, along with policy development and the completion of corrective and preventative actions emerging from the Mental Health Commission inspections and regulatory compliance. Patient quality and safety meetings reviewed the risk registers and infection prevention and control was discussed. The removal of ligatures was also discussed, as was progress in relation to the removal of same. There was service user representation at the business meetings and the patient quality and safety meetings.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 16 – 18 August 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Certificate of Registration</td>
<td>Compliant</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Notification of Deaths and Incident Reporting</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2016 and 2015:

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Admission of Children</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities.</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>✓</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

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

5.3 Areas of compliance rated Excellent on this inspection

No areas of compliance were rated excellent on this inspection.
The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents’ feedback about the approved centre.

With the residents’ permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents’ experience of the approved centre as outlined below.

The inspection team met with two residents on the third day of the inspection. All residents were complimentary in relation to the food provided. Each resident was aware of their key nurse. One resident reported that they would like to see more therapeutic activities and be provided with more information on their diagnosis and treatment. One resident reported favourably on the care and treatment provided in the approved centre. Both residents reported that they felt safe within the approved centre.
7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

- Clinical Director
- Area Director of Nursing
- Assistant Director Of Nursing
- Principal Social Worker
- Patient Quality and Safety Advisor
- Acting Executive Clinical Director
- The in-house consultant for the approved centre

The occupational therapy manager was unable to meet with the inspection team.

The area director of nursing was in the approved centre twice a week and met with all staff. Both the assistant director of nursing and the in-house consultant took part in nursing handovers and were based in the approved centre from Monday to Friday. The clinical director and the acting executive clinical director were in attendance up to four times per week. The approved centre had input from social work on just three days per week. The assistant director of nursing and the mental health administrator were trained in incident reporting management. There was a patient quality and safety advisor for the service who attended the monthly meetings on health and safety for the approved centre. Incident reports were analysed for any trends or patterns and provided information and actions in relation to this.

The approved centre did not use seclusion and sought to further reduce the episodes of physical restraint year on year. One of the ways in which this was to be achieved was to train staff in cognitive behavioural therapy techniques. There was a culture of clinical peer supervision for the medical team. Senior management supported and encouraged ongoing professional development and further education for all clinical staff. Training for all staff was a recurring theme throughout the meetings.
8.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Acting Executive Clinical Director
- Clinical Director
- Consultant Psychiatrist x2
- Senior House Officer
- Principal Social Worker
- Senior Occupational Therapist
- Area Director of Nursing
- Assistant Director of Nursing
- Business Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.
9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
Regulation 4: Identification of Residents

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

INSPECTION FINDINGS

Processes: The approved centre had a comprehensive written policy in relation to the identification of residents, which was last reviewed in 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Analysis had been undertaken in order to identify opportunities for improving the resident identification process.

Evidence of Implementation: At least two person-specific resident identifiers were used in the approved centre, and these were appropriate to the resident group and to individual needs. The identifiers, which suited residents’ communication abilities, were consulted before the administration of medication, the undertaking of medical investigations, and the provision of health care services. Appropriate resident identifiers were also used prior to the provision of therapeutic services and programmes. An alert sticker system was in place to warn staff of the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 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 did not have a written policy in relation to the provision of appropriate food and nutrition to residents.

Training and Education: There was no policy for relevant staff to have read and understood. Relevant staff interviewed were able to articulate the approved centre’s processes for food and nutrition.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis, which included consultation with residents, had been completed to identify opportunities for improving the processes relating to food and nutrition.

Evidence of Implementation: Residents in the approved centre were provided with a range of wholesome and nutritious food choices. Food was delivered from Cavan General Hospital in hot trolleys and was presented in an appealing manner. Hot meals were provided daily, and residents had access to hot and cold drinks and to a fresh water fountain in the dining room. Menus were approved by a dietician from Cavan General Hospital.

The needs of residents identified as having special nutritional requirements were not reviewed by a dietician, and residents did not have formal or regular access to a dietician. No evidence-based nutrition assessment tool was in use in the approved centre. Weight charts were implemented, monitored, and acted upon for residents, where necessary. Nutritional and dietary needs were documented in residents’ individual care plans, where relevant. Intake and output charts were maintained, as required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
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 did not have a written policy in relation to food safety.

Training and Education: Relevant staff interviewed were able to articulate the processes relating to food safety in the approved centre. Food-handling staff – multi-task assistants and nursing staff – had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented.

Monitoring: There was documented evidence that food safety audits had been completed. Food temperatures were recorded in line with food safety recommendations, and a log sheet was maintained. Analysis had been undertaken to identify opportunities for improving food safety processes.

Evidence of Implementation: Food was delivered from Cavan General Hospital in hot trolleys. Adequate hand-washing areas were in place for catering services, and there was suitable and sufficient catering equipment. Appropriate facilities were provided for the refrigeration, storage, cooking, and serving of food. Hygiene was maintained to support food safety, and the kitchenette and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to clothing, which was last reviewed in May 2015. Entitled *The Management of the Prescribed Use of Night Attire as Part of a Treatment Plan*, it included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could clearly articulate the processes in relation to residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was checked regularly by a multi-task assistant, but this was not documented. A record of residents wearing nightclothes during the day was kept and monitored.

Evidence of Implementation: Residents were supported to keep and wear personal clothing, and each had personal space for storing clothes. Residents’ clothing was observed to be clean and appropriate to their needs. No residents were wearing nightclothes during the day at the time of the inspection. Hospital scrubs and disposable underwear were used as emergency pyjamas, and there was a petty cash account for purchasing emergency clothing, where required. All residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of information on staff roles and responsibilities in terms of the management of personal property and possessions.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the procedures relating to residents’ property and possessions, as set out in the policy.

Monitoring: Personal property logs were maintained and monitored. Analysis had been completed to identify opportunities for improving the processes around residents’ personal property and possessions, and it found 66% compliance with the Judgement Support Framework.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their individual care plans (ICPs). Personal property was secured in a locked room in individual boxes, and valuables, including monies, were kept in a locked cabinet in the nurses’ station, also in individual boxes. Residents were provided with lockers and cabinets for storing personal effects. Signed property checklists were drawn up at admission and subsequently maintained, and these were stored in the clinical file and kept separately from ICPs.

Two members of staff or one member of staff and the resident or their representative oversaw the process of providing residents with access to their monies. Signed records of staff issuing money were retained and countersigned by the resident or their representative.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to the provision of recreational activities.

Training and Education: There was no policy for relevant staff to have read and understood. Relevant staff interviewed could articulate the processes relating to the provision of recreational activities in the approved centre.

Monitoring: The occurrence of planned activities, including details of resident uptake/attendance, was not recorded. Analysis had been completed to identify opportunities for improving the processes relating to recreation, and it found 80% compliance with the Judgement Support Framework.

Evidence of Implementation: Residents had access to appropriate recreational activities, with resources that included a gym with exercise equipment, TV rooms with DVDs and books, a CD library, board games, newspapers, playing cards, baking, computing, and gardening. A weekly timetable of activities was displayed. Recreational activities were scheduled on weekdays, and baking and walking groups as well as movie nights and outings were scheduled at weekends.

Residents were facilitated in providing input into the activities schedule at weekly meetings, and they had access to indoor and outdoor exercise and physical activity. When necessary, individual risk assessments were completed for residents in relation to the selection of appropriate activities. Residents’ decisions on whether or not to participate in activities were respected. Recreational activities were appropriately resourced, and communal areas were suitable for recreation.

Records of resident attendance at events were not comprehensive.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in September 2015. The policy included all of the requirements of the Judgement Support Framework, and it referenced the HSE’s cultural diversity guidelines.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: Analysis of the policy’s implementation was completed in September 2016, and it achieved 83.9% compliance with the Judgement Support Framework.

Evidence of Implementation: Residents were facilitated in the practice of their religion, and staff were supportive of residents’ religious and cultural preferences. There was an oratory in the nearby general hospital, where residents could access religious services, and quiet rooms for prayer could be made available in the approved centre. Residents had access to multi-faith chaplains when required, and they could attend religious services outside the approved centre, where appropriate and following an assessment. Other religious and spiritual needs were also supported.

Residents’ religious needs were assessed on admission, and the care and services provided respected their religious and spiritual requirements. Residents were supported in observing or abstaining from religious practice in line with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.
(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.
(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.
(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.
(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.
(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to visits, which was last reviewed in August 2016. The policy included requirements of the *Judgement Support Framework*, with the exception of details of the required visitor identification methods.

**Training and Education:** Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to visits, as set out in the policy.

**Monitoring:** At the time of the inspection, there were no restrictions on residents’ rights to receive visitors. There was documentary evidence that analysis had been completed to identify opportunities for improving visiting processes.

**Evidence of Implementation:** Visiting times, which were appropriate and reasonable, were publicly displayed at the entrance to the approved centre and in an information leaflet. There were up to four rooms in which residents could meet visitors in private: a family room, consultation room, quiet room, and a small communal room. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Children were welcomed when accompanied and supervised all times. The family room, which had en suite toilet facilities and a selection of toys, was comfortably furnished and suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and training and education pillars.
Regulation 12: Communication

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in August 2015. It included requirements of the Judgement Support Framework, with the exception of a process for assessing residents’ communication needs and the individual risk assessment requirements in relation to limiting resident communication.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Staff interviewed could articulate the processes for facilitating residents’ communication, as set out in the policy.

Monitoring: There was documentary evidence that residents’ communication needs and restrictions on communication were monitored daily in progress notes and at weekly multi-disciplinary team meetings. An audit had been undertaken in September 2016 to identify opportunities for improving communication processes, and it achieved 83% compliance with the Judgement Support Framework. Analysis had been completed and an action plan put in place on foot of the audit.

Evidence of Implementation: Residents had access to external communications, including post, fax, email, and Internet. They could keep their own mobile phones and were directed to the mobile phone policy, which was clearly displayed on the noticeboard.

Where necessary, individual assessments were completed for residents in relation to risks associated with external communications. Needs were documented in the risk assessment and in the resident’s individual care plan. A senior member of staff could examine resident communication only where there was reasonable cause to believe that the communication may result in harm to the resident or others. No resident communications had been subject to examination since the 2016 inspection.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.
(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.
(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.
(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.
(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.
(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident’s dignity, privacy and gender.
(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.
(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.
(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in November 2015. It covered requirements of the Judgement Support Framework, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she was accommodated.
- The consent requirements of a resident regarding searches and the process for conducting searches in the absence of consent.
- The process for dealing with illicit substances found during a search.

The policy did not include processes for communicating the approved centre’s search policies and procedures to residents and staff.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the procedures relating to searches, as outlined in the policy. The inspection team was presented with the pro-forma document used in the event of a resident search.

As no searches had been conducted in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the care of the dying. Entitled *End of Life Care and the Deceased Resident*, it was dated January 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policy.

As no resident had received end of life care in the approved centre since the 2016 inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to the development, use, and review of individual care plans (ICPs). The inspection team was furnished with a draft policy only.

Training and Education: There was no approved plan for clinical staff to have read and understood. Clinical staff interviewed were able to articulate the processes relating to individual care planning in the approved centre. There was no evidence to demonstrate that all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: ICPs were audited on a quarterly basis to assess their compliance with the regulation. Analysis had been completed to identify opportunities for improving the individual care planning process. Nursing metrics and audits had examined specific aspects of the regulation on ICPs to ensure that the approved centre was compliant with same.

Evidence of Implementation: Seven ICPs were examined by the inspection team. Each was a composite set of documentation that was identifiable and uninterrupted. ICPs were stored in a designated section within the clinical files and were kept separately from progress notes.

Residents received a comprehensive assessment at admission, from which an initial care plan was developed. Evidence-based assessments were used where possible. The approved centre had developed a pre-MDT assessment, which was completed by the resident and incorporated into the ICP. Individual MDT ICPs were completed within seven days of the resident’s admission. The ICPs identified residents’ assessed needs and specified appropriate goals and the resources required to provide the care and treatment identified.

In all cases, a key worker was appointed to ensure continuity in the implementation of the ICP, an individual risk management plan was in place, and a preliminary discharge plan had been developed. The ICPs were reviewed by the MDT weekly and updated in line with residents’ changing needs, condition, circumstances, and goals.

Residents were given the opportunity to access their ICPs, but the document template did not include space to record that residents had been offered copies of their ICPs. Where a resident declined or refused a copy of their ICP, this was recorded and explained.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and evidence of implementation pillars.
Regulation 16: Therapeutic Services and Programmes

| COMPLIANT | Quality Rating | Satisfactory |

(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 did not have a written policy in relation to the provision of therapeutic services and programmes to residents. The inspection team was presented with a draft policy only.

**Training and Education:** There was no approved policy for staff to have read and understood. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes in the approved centre.

**Monitoring:** There was evidence that the range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had been completed to identify opportunities for improving the processes relating to the provision of therapeutic services and programmes. There was also a Therapeutic Activity Programme Development Committee.

**Evidence of Implementation:** The range of available, evidence-based programmes was appropriate to the assessed needs of the residents, as outlined in their individual care plans (ICPs). The therapeutic services and programmes provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A comprehensive range of programmes was provided by the occupational therapist (OT) and nursing staff, with input from the art therapist. These included art therapy, anxiety management, stress management and coping skills, goal settings, activities of daily living, stress management, wellness recovery action planning, and recovery, current affairs, cooking, relaxation, and life skills groups. The social worker delivered programmes on social entitlements, recovery, and wellness.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, and separate, dedicated rooms were available for their delivery. The approved centre also had a dedicated occupational therapy kitchen and dedicated exercise room. The OT, social worker, and nursing staff maintained a record of residents’ participation and engagement in and of outcomes achieved in therapeutic services or programmes, and this was reflected in residents’ ICPs.

Where residents required a service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
## Regulation 17: Children’s Education

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

### INSPECTION FINDINGS

As no child who required educational services had been admitted to the approved centre since the 2016 inspection, this regulation was not applicable.
Regulation 18: Transfer of Residents

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the transfer of residents, which was dated 2017. It included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

**Monitoring:** The approved centre did not maintain a transfer log. Analysis had been completed on the transfer process to identify opportunities for improving the provision of information during transfers.

**Evidence of Implementation:** The clinical file of one resident who had been transferred to another health care facility was inspected. Communication with the receiving facility was documented. This included a comprehensive referral letter detailing the reasons for the transfer, a risk assessment, and a record of the resident’s accompaniment during the transfer.

Consent to the transfer was not received from the resident, who was clinically unable to give consent, and this was documented. A medical/nursing assessment was conducted prior to the transfer, and all relevant information regarding the resident was transferred to the receiving facility. The clinical file contained a letter of referral, including a list of required medications.

No resident transfer form had been completed, and there was no checklist to ensure that resident records had been transferred. There were good records of the communications between the receiving facility, the resident’s next of kin, and the approved centre in advance of the transfer. Copies of these were retained in the clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education, monitoring, and evidence of implementation pillars.
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to the provision of general health care to residents, dated February 2017, and for responding to medical emergencies, which was last reviewed in December 2015. The responding to medical emergencies policy included all of the requirements of the Judgement Support Framework. The general health policy included requirements of the Judgement Support Framework, with the following exceptions:

- Details of the resource requirements for general health services, including equipment needs.
- The process for protecting resident privacy and dignity during general health assessments.
- The incorporation of general health needs into the resident individual care plan.
- The referral process for residents’ general health needs.
- The documentation requirements in relation to general health assessments.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the medical emergencies policy. Not all clinical staff had read and understood the general health policy. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes was not recorded and monitored. A system was in place to ensure that residents had six-monthly general health reviews, but this had not been systematically reviewed. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had a resuscitation trolley and an Automated External Defibrillator, both of which were checked weekly. Records were available of medical emergencies that occurred in the approved centre, along with details of the care provided.

Registered medical practitioners assessed residents’ physical health on admission and on an ongoing basis. Residents received appropriate general health care in line with their individual care plans, and their general health needs were monitored and assessed at least every six months. Only one resident had been
in the approved centre for more than six months, and the relevant clinical file indicated that the required physical review had been completed by medical staff.

Residents could access general health services or be referred to other health services through Cavan General Hospital, as required. Records were maintained of residents’ completed general health checks and the associated results. Residents had access to national screening programmes but were not provided with information on the screening programmes available through the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
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 policy in relation to the provision of information to residents, which was last reviewed in August 2014. It included requirements of the Judgement Support Framework, with the exception of the process for providing information to residents with specific communication needs.

Training and Education: Not all staff had acknowledged that they had read and understood the policy. Staff interviewed could articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information had been monitored in the approved centre, leading to the introduction of an information leaflet for residents and their families. Analysis had been undertaken to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission in a booklet. This included details of the available care and services and of housekeeping arrangements, complaints procedures, visiting times and arrangements, advocacy services, and residents’ rights.

Residents were informed about their multi-disciplinary team (MDT). They received written and verbal information about their diagnosis, unless, in the view of the treating psychiatrist, this might be detrimental to their health and well-being. They were also advised about the likely adverse effects of treatments.

Medication sheets in a format appropriate to residents’ needs were available in a medication information folder. They contained evidence-based information on indications for the use of all medication administered to residents, including possible side-effects. Where necessary, residents had access to interpretation and translation services.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and training and education pillars.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in March 2016. The policy included all aspects of the Judgement Support Framework including staff roles and responsibilities in relation to privacy and dignity and the processes to be applied where resident privacy and dignity is not respected by staff.

Training and Education: Not all staff had signed a log indicating that they had read and understood the policy. Staff interviewed could articulate the processes for ensuring resident privacy and dignity.

Monitoring: An annual review had been undertaken using the mental health service assessment tool to ensure that the approved centre’s policy was being implemented and that the premises and facilities were conducive to resident privacy. An analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to be polite, friendly, and sympathetic to residents’ needs. Staff were appropriately attired, sought permission before entering residents’ rooms, and conducted all conversations relating to residents’ clinical and therapeutic needs with discretion. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors with an override facility. In shared rooms, adequate and suitable privacy screening was in place around the beds.

Not all observation panels were appropriately screened. An observation room between male and female dormitories allowed residents to see into either room, which compromised privacy. Observation panel levers in two unoccupied rooms were broken and stuck in open and partially open positions. Although dorm rooms overlooked a publicly accessible area, the windows were not fitted with opaque glass to ensure privacy.

Noticeboards did not display identifiable resident information. Residents had their own mobile phones and were facilitated in making calls in private where necessary.

The approved centre was not compliant with this regulation because residents’ privacy and dignity was not ensured due to the following:

a) The use of clear glass in bedrooms facing a publicly accessible area.
b) The presence of broken observation window levers in two single rooms.
c) The ability of residents to view opposite-sex residents through an observation room.
(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 did not have a policy in relation to its premises.

Training and Education: There was no policy in place.

Monitoring: The approved centre had not completed a hygiene audit, and no ligature audit had been undertaken since September 2014. An audit on the premises had been conducted, but there had been no analysis of the outcomes.

Evidence of Implementation: The approved centre’s physical environment provided an opportunity for residents to maintain and improve their mental and general health, with adequate indoor and outdoor spaces available. Residents had access to personal space, including suitable accommodation, and to shared space in the form of appropriately sized communal rooms. Communal areas were adequately lit to facilitate reading and other activities. Rooms were comfortably heated and ventilated and contained plenty of soft furnishings. Appropriate signage and sensory aids were in place, and hazards such as large open spaces, steps, slippery floors, hard and sharp edges, and hard or rough surfaces had been minimised. Ligature points had not been minimised; the inspectors observed ligature points in the en suite bathrooms of the single rooms.

The approved centre was in a reasonable state of repair, but issues such as stained tiles and damaged internal walls and floor tiles were observed during the inspection. There was no structured programme of general or decorative maintenance. There was a system of reactive maintenance, where issues were
flagged online with the general hospital and sent for approval and budget allocation before being remedied.

A cleaning schedule was implemented for five hours per day, and the approved centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed. There were adequate toilet and bathroom facilities, including assisted needs facilities. These were conveniently located and clearly identified. There were designated sluice, cleaning, laundry, and therapy/examination rooms.

Bedrooms were adequately sized to address residents’ needs, and furnishings throughout the approved centre supported residents’ independence and comfort.

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

a) Stained tiles and damaged internal walls and floor tiles were contrary to 22(1)(a).
b) There was no programme of routine maintenance, 22(1)(c).
c) Ligature points had not been removed in the en suite bathrooms of single bedrooms, 22(3).
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 in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in December 2016. It included all of the requirements of the Judgement Support Framework. The policy required further review to remove reference to the process for administering medication to a patient who was unwilling to give consent.

Training and Education: Not all nursing and medical staff had acknowledged that they had read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to up-to-date information on all aspects of medication management. All clinical staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been completed to determine compliance with the policies and procedures and with relevant legislation and guidelines. Incident reports were recorded for all incidents involving medication using the National Incident Management System report form. Analysis to identify opportunities for improving medication management had not been completed.

Evidence of Implementation: An MPAR was maintained for each resident, and 12 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full, and generic names were recorded where applicable. The MPARS contained space for recording routine, once-off, and as-required medications. The dosage and the administration route for medications were recorded, and all medications administered to residents were listed. The allergy section was completed in each MPAR.

One MPAR did not record the frequency of medication administration, one did not record the start date for medication, and two did not record discontinuation dates for medication. Medications refused by residents were not documented, and the Medical Council Registration Number (MCRN) of the medical practitioner prescribing medication was not included on one MPAR.

Residents’ medication was reviewed at least six-monthly, and MPARs were rewritten where necessary. Where there were alterations in the medication order, the medical practitioner rewrote the prescription. Medication was administered by two registered nurses in accordance with the directions of the prescriber. The expiration date of the medication was always checked prior to administration, and good hand-hygiene
and cross-infection control techniques were implemented during the dispensing of medications. In the event that a resident’s medication was withheld or a resident refused medication, this was documented in the MPAR. Controlled drugs were checked by two staff members against the delivery form and recorded in a controlled drug book.

Medication arriving from the pharmacy was verified against the order by two nurses and stored in a medication room with two fridges. Food and drink were not kept in medication storage areas. Only one of the fridges had a temperature log, which was not routinely filled in. The fridges were also in need of cleaning.

The medication trolley was locked and secured or attended at all times. When not in use, it was locked to the wall of the medication room. A system of stock rotation was in place, with unused stock returned to the pharmacy. Nurses checked the medications for each patient twice a week to ensure an adequate supply and to check the dates, but no formal monthly inventory of medications was conducted. Out-of-date medication was found in one of the medication fridges during the inspection.

The approved centre was not compliant with this regulation because it did not have appropriate and suitable practices relating to the ordering, prescribing, storing, and administration of medicines, 23(1):

a) The MCRN was not evident on one MPAR.

b) The start and discontinuation dates and the frequency of administration were not recorded on all MPARs.

c) Out-of-date medication was found in one of the medication fridges.

d) Medication fridges were not clean.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written safety statement incorporating a safety policy, which was last reviewed in October 2016. The safety statement referenced the Community Infection Prevention Control Manual (November 2011). It included requirements of the Judgement Support Framework, with the exception of the process for providing support to staff following exposure to infectious diseases.

Training and Education: Not all staff had signed a log indicating that they had read and understood the policy and safety statement. Staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy.

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

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

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

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

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

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

INSPECTION FINDINGS

As CCTV was not in use in the approved centre, this regulation was not applicable.
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 three written policies in relation to staffing: a policy on the provision of statutory and mandatory training for all staff in the Cavan/Monaghan area, dated February 2017; a policy on the appointment to positions in the civil and public service, dated March 2017; and a policy on the recruitment of agency staff, dated March 2017. There was also a new draft staffing policy, which had not been approved at the time of the inspection.

The policies covered three requirements of the Judgement Support Framework: the use of agency staff, the roles and responsibilities in relation to staff training processes, and the ongoing staff training requirements and frequency of training needed. They did not reference the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff in the approved centre.
- The recruitment, selection, and appointment process, including Garda vetting requirements.
- The organisational structure of the approved centre, including lines of responsibility.
- The job description requirements.
- The staff planning requirements to address the number and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- Details of the staff rota and the methods applied for its dissemination to staff.
- Staff performance and evaluation requirements.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- Details of orientation and induction training for all new staff.
- The required qualifications of training personnel.
- The evaluation of training programmes.
**Training and Education:** Not all relevant staff had signed a log indicating that they had read and understood the policies. Staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

**Monitoring:** The staff training plan was reviewed regularly to ensure its implementation and effectiveness, and training was booked on an ongoing basis. The numbers and skill mix of staff were reviewed against the levels recorded in the approved centre’s registration, and clinical requirements defined the need for extra staff. There was documented evidence from governance and risk management meetings that analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

**Evidence of Implementation:** The approved centre had an organisational chart to identify the leadership and management structure and lines of authority and accountability, which was available in the safety statement. Staff were appointed via the HSE’s National Recruitment Service, and all staff were appropriately vetted. There was a planned and actual staff rota in place. The rota was computerised centrally, with copies distributed to each unit weekly. The numbers and skill mix of staffing met resident needs, and staff were qualified for their roles. An appropriately qualified staff member was on duty and in charge at all times.

No written staffing plan was made available to the inspection team.

Where agency staff were used, they were Garda vetted and their registration and identity were confirmed by the nurse on call. However, there was no documentary evidence that agency staff had received required training in fire safety, Basic Life Support (BLS), management of violence and aggression, and the Mental Health Act 2001.

Annual staff training plans were completed for all staff, and skills development was in line with resident needs, as outlined in their individual care plans. Staff were receiving training in addiction and recovery studies, and the executive management team aspired to train all staff in cognitive behavioural therapy.

Not all staff had up-to-date, mandatory training: 11 did not have Basic Life Support training, one did not have training in the management of violence and aggression, two had not completed fire safety training, and eight were not trained in the Mental Health Act 2001.

Twenty-four staff had Children First training. Staff were trained in accordance with the assessed needs of residents, and courses had been delivered in elder abuse, manual handling, medication management, hand hygiene, Trust in Care, care for residents with an intellectual disability, risk assessment, assisted admissions, preceptor training, and Electro-Convulsive Therapy. Five members of staff had been trained in Wellness Recovery Action Planning.

All staff training was documented, and staff training logs were maintained. There was evidence that opportunities for further education were available to staff and that in-service training was delivered in an
appropriate setting by suitably trained and competent individuals. The MHA 2001, the associated regulations, Mental Health Commission rules and codes were available to staff.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Psychiatric Unit</td>
<td>CNM2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>MTA</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Multi-Task Assistant (MTA)*

The approved centre was not compliant with this regulation because not all staff had received the required training in BLS, fire safety, the management of aggression and violence, and the MHA 2001, 26(4) and (5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in 2016. It covered requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

The policy did not refer to record review requirements or include the process for the retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed a log indicating that they had read and understood the policy. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policy. Clinical staff had not received training in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had been conducted to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were stored in locked filing cabinets in a locked room, and all residents had a personal file. Clinical files were up to date and in good order, and they were reflective of the residents’ current status and the care and treatment being provided. Files were maintained using resident-specific identifiers: name, date of birth, and medical record number. Clinical
files were developed and maintained in a logical sequence so as to ensure completeness, accuracy, and ease of retrieval. There were dedicated sections for the individual care plan, clinical investigations, clinical notes, nursing assessments, and risk assessments.

Records were accessible only by authorised staff, who had authority to make entries in them. They contained factual, consistent entries written legibly in black ink, dated, time stamped using the 24-hour clock, and accompanied by a signature.

Documentation relating to food safety, health and safety, and fire inspections was maintained. Records were retained/destroyed in accordance with legislative requirements and the approved centre’s policy and procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and training and education pillars.
Regulation 28: Register of Residents

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date and contained all of the required information listed in Schedule 1 to the Mental Health Act 2001.

The approved centre was compliant with this regulation.
### 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 did not have a written policy on the development and review of operating policies and procedures.

**Training and Education:** There was no policy for staff to have read and understood. Staff had received training on operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies in the approved centre.

**Monitoring:** There was documentary evidence that an annual audit was undertaken to determine compliance with review time frames. Analysis had been completed by the Terms of Reference Quality and Patient Safety Committee to identify opportunities for improving the process of developing and reviewing policies.

**Evidence of Implementation:** Operating policies and procedures were developed with input from both clinical and managerial staff and in consultation with relevant stakeholders. They incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved and communicated to all relevant staff.

All operating policies and procedures mandated by the regulations were reviewed within the required three-year time frame, and obsolete versions were removed from circulation. Policies were presented in a standardised format that included the title, reference and version number, names of approvers, and dates of implementation and review. They did not list the document owners or reviewers, where applicable. Where generic policies were used, the approved centre had a written statement adopting said policies.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and evidence of implementation pillars.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to the facilitation of Mental Health Tribunals.

Training and Education: Relevant staff interviewed were able to articulate the procedure for facilitating Mental Health Tribunals in the approved centre.

Monitoring: Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the tribunal’s process. Staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 31: Complaints Procedure

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in December 2014. It included requirements of the Judgement Support Framework, with the following exceptions:

- The process for communicating the complaints policy and procedure to residents, their representatives, family, next of kin, and visitors.
- The process by which any person could make a complaint by e-mail or using complaint, feedback, or suggestions forms.
- The confidentiality requirements in relation to complaints.

Training and Education: Relevant staff had not received formal training on complaints management processes. Not all staff had signed a log indicating that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: An audit of the complaints log had been completed, it found 99% compliance with the regulation. Complaints data had not been analysed for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. An advocate attended the approved centre on a weekly basis to facilitate the participation of residents and their representatives in the complaints process.
The approved centre’s management of complaints was well publicised and accessible. There was no evidence that the quality of service, care, and treatment of a resident was adversely affected by reason of a complaint being made.

A complaints log was maintained, and all non-minor complaints were dealt with by the nominated person and recorded. Where minor complaints could not be addressed locally, they were escalated in accordance with the approved centre’s policy, and this was recorded in the complaints log.

A review of five complaints lodged since the 2016 inspection found inadequate documentation of complaints. Details of the complaints and of subsequent investigations and outcomes were not fully recorded. There was no evidence that complainants were informed promptly of the outcome of the investigation or provided with details of the appeals process. Complainants’ satisfaction/dissatisfaction with the investigation findings was not recorded.

The approved centre was not compliant with this regulation because the five complaints submitted since the 2016 inspection were not appropriately documented, 31(7).
(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**

The approved centre had a new written policy on risk management, dated February 2017. A number of other policies were also relevant to the managing of risk, including the safety statement, the HSE’s *Risk Management in Mental Health Services* document, the *Safety Incident Management Policy*, the patient management policy, and the medical emergency policy. The policies covered requirements of the *Judgement Support Framework*, including details of the roles and responsibilities in relation to risk management and the implementation of processes for the following:

- Identifying, assessing, treating, reporting, and monitoring organisational risks, structural risks, risks to the resident group and to individual residents during the delivery of care and services, and health and safety risks to the residents, staff, and visitors.
- Controlling risks such as resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents of the approved centre.
- Recording and reporting incidents.
- Investigating incidents.
- Reviewing and monitoring incidents.
- Responding to emergencies.
- Protecting children and vulnerable adults in the care of the approved centre.

The policy did not reference capacity risks relating to the number of residents in the approved centre.
Training and Education: Not all relevant staff had been trained in the identification, assessment, management, and documentation of risk. Relevant staff had received training in risk management processes in relation to incident reporting and health and safety risks. Clinical staff were trained in individual risk management, and management staff had received training in organisational risk management. Not all staff had signed a log indicating that they had read and understood the policies. Staff interviewed were able to articulate the risk management processes, as set out in the policies. All risk management training was documented.

Monitoring: The risk register was discussed monthly at patient quality and safety meetings, but no quarterly audits had been undertaken to determine compliance with the approved centre’s risk management policies. All incidents were recorded and risk-rated using the National Incident Management System (NIMS). No analysis of incident reports had been completed.

Evidence of Implementation: The approved centre had a designated patient quality and safety risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest practical level. Clinical risks and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored. Work to address structural risks, including ligature points, was ongoing.

Five clinical files were examined in relation to risk management. The approved centre completed risk assessments of residents at admission, before and during resident transfer and discharge, and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDT) had input into the development, implementation, and review of individual risk management processes, as did residents and their representatives. The requirements for the protection of vulnerable children and adults were appropriate and implemented as necessary.

In one of the files inspected, there was no documentary evidence that a risk assessment had been undertaken before an episode of physical restraint.

Risk was reviewed at the weekly MDT meetings or as required, and family input was documented in the clinical files. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. There was an emergency plan in place, which incorporated evacuation procedures.

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
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 **

The approved centre had an up-to-date certificate of registration, which was displayed prominently.

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

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
   (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
   (b) where the patient is unable to give such consent –
      (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist
          responsible for the care and treatment of the patient, and
      (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant
          psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-
    convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

As no resident of the approved centre had received Electro-Convulsive Therapy since the 2016 inspection, this rule was not applicable.
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 contraves 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.
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

As mechanical means of bodily restraint were not used in the approved centre, this rule was not applicable.
11.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
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

The files relating to two patients who had been in the approved centre for more than three months and who were in continued receipt of medication were inspected. A Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed for one patient and a consent to the continued administration of medication form was completed for the other. Copies of these were retained in the respective clinical files.

Both documents included details of the following:

- The names of the medications prescribed.
- Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication.
- Discussion with the patient in terms of the nature and purpose and effects of the medication.
- Supports provided to the patient with regard to the discussion and their decision-making process.
The consent to treatment document included evidence that the responsible consultant psychiatrist undertook a capacity assessment of the resident. Form 17 included details of the views on treatment expressed by the patient and an authorisation of the medication by a second consultant psychiatrist.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy on the management of physical restraint, dated December 2016. It was reviewed annually and met all the criteria for this code of practice. It documented procedures for the provision of information to residents undergoing restraint, specified who could initiate and conduct physical restraint, and outlined child protection processes. The policy included staff training requirements such as the frequency of training, those who should receive training, areas to be addressed during training, the identification of appropriately qualified persons to deliver training, and alternatives to the use of physical restraint.

Training and Education: Not all staff had signed a log indicating that they had read and understood the policy. A record of staff attendance at training on the use of physical restraint was maintained in a staff training folder along with a needs analysis. Restraint was never used to ameliorate staff shortages.

Monitoring: An annual report on the use of physical restraint in the approved centre was provided to the inspection team.

Evidence of Implementation: The files relating to five episodes of physical restraint in the approved centre were inspected. These indicated that the use of physical restraint was rare, that it was initiated in patients’ best interests, and that staff had first considered other interventions. The episodes of restraint were not prolonged beyond the period necessary to prevent immediate and serious harm to the patient or others, were initiated by appropriate members of staff. In one episode inspected, physical restraint was not based on a risk assessment. In all cases, cultural awareness and gender sensitivity were demonstrated.

A designated staff member served as lead in each episode of restraint. The consultant psychiatrist was notified of the use of restraint as soon as was practicable, and a registered medical practitioner attended the residents and conducted a physical examination within three hours of the start of the episodes. The consultant psychiatrist signed and dated the clinical practice form within 24 hours, and there was documentary evidence that members of the multi-disciplinary team (MDT) reviewed and recorded episodes in the relevant clinical files within two working days. Residents were afforded an opportunity to discuss the use of restraint with members of the MDT.

In each case, the resident was informed of the reasons for the restraint, its likely duration, and the circumstances in which physical restraint would be discontinued.
The approved centre was not compliant with this code of practice for the following reasons:

(a) There was no written record that all staff had read and understood the policy on the use of physical restraint, 9.2(b).

(b) In one episode, there was no evidence that the use of physical restraint was based on risk assessment, 1.7.
Admission of Children

NON-COMPLIANT
Risk Rating
MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of children, which was dated April 2016. It covered all of the requirements of this code of practice:

- The conducting of individual risk assessments on each child.
- The policy and procedures relating to family liaison, parental consent, and confidentiality.
- The process for identifying the person responsible for notifying the Mental Health Commission (MHC) of the admission.

Training and Education: There was documentary evidence that staff had been trained in the care of children. Twenty-four staff members had received Children First training.

Evidence of Implementation: There had been one child admission since the 2016 inspection. The resident was admitted for one night, and provisions were put in place to ensure his/her safety: the use of level 1 nursing observations and the allocation of a single room. The approved centre was an acute adult service. It did not have age-appropriate facilities and programmes and did not respond to the child’s special requirements as a young person in an adult setting. It was not documented that the right of the child to have his/her views heard was ensured. Although the child had been given a copy of the Headspace Toolkit, there was nothing to indicate that his/her rights had been explained in an accessible manner. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were not available in the approved centre and were accessed online.

Advice had been sourced from the Child and Adolescent Mental Health Service, appropriate visiting arrangements were in place for family members, and consent for treatment was obtained from one or both parents. The MHC was notified of the admission within the required 24-hour time frame.

The approved centre was not compliant with this code of practice for the following reasons:

a) Age-appropriate facilities and activities were not provided, 2.5(b).

b) The special requirements of the child in an adult setting were not addressed, 2.5(c)(ii).

c) The child’s right to have his/her views heard was not documented, 2.5(c)(iii).

d) Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were not available in the approved centre, 2.5(d)(ii).

e) There was no evidence that the child had his/her rights explained in an accessible manner, 2.5(g).
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

The approved centre had a risk management policy that covered the notification of deaths and incident reporting to the Mental Health Commission (MHC). The policy met all the criteria of this code of practice. It specified the risk manager and outlined the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The completion of death notification forms.
- The submission of forms to the MHC.
- The completion of six-monthly incident summary reports.

Training and Education: Staff were aware of and understood the policy and this was documented. Staff interviewed were able to articulate the processes relating to the notification of deaths and incident reporting.

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

Evidence of Implementation: The approved centre’s incident reporting process was compliant with Regulation 32: Risk Management Procedures. The National Incident Management System was used for reporting incidents, and a standardised incident report form was available to the inspection team. A six-month summary of all incidents was sent to the MHC.

No deaths had been reported in the approved centre since the 2016 inspection.

The approved centre was compliant with this code of practice.
INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to working with people with an intellectual disability. It reflected person-centred treatment planning, presumption of capacity, and least restrictive interventions, and it included a protocol to ensure appropriate and relevant communication and liaison with external agencies for people with an intellectual disability. It did not reference the following:

- The roles and responsibilities of staff members working with people with an intellectual disability.
- The management of problem behaviours.
- The process for ensuring appropriate and relevant communication and liaison with external agencies.
- The procedures for training staff in working with people with an intellectual disability.

Training and Education: Thirteen members of staff had completed relevant training, including training in person-centred approaches, human rights principles, and preventative and responsive approaches to problem behaviours.

Monitoring: The policy had been reviewed within the required three-year time frame. There was evidence that the use of restrictive practices was reviewed periodically.

Evidence of Implementation: Given that there was no resident in the approved centre with an intellectual disability at the time of the inspection, the centre was not assessed against the evidence of implementation pillar of this code of practice.

The approved centre was not compliant with this code of practice because the policy did not reference the following:

a) The roles and responsibilities of staff members in terms of working with people with an intellectual disability, 5.2.
b) The management of problem behaviours, 5.3.
c) The procedures for training staff in working with people with an intellectual disability, 6.2.
d) The process for ensuring appropriate and relevant communication and liaison with external agencies, 7.2.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

As no resident of the approved centre had received Electro-Convulsive Therapy since the 2016 inspection, this code of practice was not applicable.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was dated 2015, included all of the criteria of this code of practice, including processes relating to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment, and it contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams. The approved centre had a separate, up-to-date policy on confidentiality, privacy, and consent.

Transfer: The transfer policy, dated 2017, detailed how a transfer was arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary, emergency, and overseas transfer. It did not reference the safety of residents and staff during a transfer.

Discharge: The approved centre had a discharge policy, which was last reviewed in November 2014. It included procedures for discharging involuntary patients, homeless people, and elderly people and for managing discharge against medical advice. A protocol for discharging people with an intellectual disability was included in a separate intellectual disability policy. The discharge policy referenced prescriptions and supply of medication on discharge and post-discharge relapse prevention strategies. Its follow-up protocols did not include the following:

- An outline of the roles and responsibilities of staff in relation to providing follow-up care.
- Details of when and how much follow-up contact residents should have.
- A process for following up and managing missed appointments.

Training and Education: There was no documentary evidence that staff had read and understood the admission and transfer policies. All staff had signed a log indicating that they had read and understood the policy on discharge.

Monitoring: There was no evidence that an audit had been completed on the implementation of and adherence to the admission and discharge policies.

Evidence of Implementation:

Admission: One clinical file was reviewed in relation to admission. The approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on
the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). The resident was assessed at admission, and assessments and examinations were documented in the clinical file. The assessment included a history of the presenting problem; a psychiatric, family, medical, and social history; details of current and past medication; and mental state and physical examinations. There was evidence of family involvement in the admission process. The resident was admitted to the unit most appropriate to his or her needs.

The approved centre’s admission process was compliant under Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, Regulation 27: Maintenance of Records, and Regulation 32: Risk Management.

**Transfer:** The approved centre’s transfer process was compliant with Regulation 18: Transfer of Residents. The clinical file of one resident who was transferred to another approved centre was examined. The decision to transfer was made by the RMP following a medical review and was agreed with the receiving facility. A pre-transfer assessment, including a risk assessment, was undertaken. The reason why the resident’s consent to transfer was not obtained was documented, and appropriate MDT and family involvement in the process was recorded. A copy of the referral letter was retained in the clinical file.

**Discharge:** The file of one resident was inspected in relation to discharge. The decision to discharge was taken by the RMP, and the file evidenced good discharge planning, with family consultation and appropriate MDT input. A discharge plan was in place as part of the resident’s individual care plan.

The resident had a comprehensive assessment prior to discharge, which included an evaluation of psychiatric and psychological needs, a mental state examination, and a risk assessment. The discharge was coordinated by the resident’s key worker. Preliminary and comprehensive discharge summaries were sent to the relevant primary care team within the required time frames. These included details of diagnosis, prognosis, medication, outstanding health or social issues, and follow-up arrangements. A timely follow-up appointment was arranged.

The approved centre was not compliant with this code of practice for the following reasons:

- a) The transfer policy did not reference the safety of the resident and staff during transfer, 4.13.
- b) The discharge policy’s follow-up procedures did not reference crisis management planning, the roles and responsibilities of staff in providing follow-up care, when and how much follow-up contact a resident should have, and a process for following up and managing missed appointments, 4.14.
- c) There was no evidence that staff had read and understood the admission and transfer policies, 9.1.
- d) There was no evidence that an audit had been completed on the implementation of and adherence to the admission and discharge policies, 4.19.
## Appendix 1 – Corrective and Preventative Action Plan

### Regulation 21: Privacy

*Report reference: Page 42*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td><strong>Reoccuring</strong>^1^ or <strong>New</strong>^2^ area of non-compliance</td>
<td><strong>Provide corrective and preventative action(s) to address the area of non-compliance</strong></td>
<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
</tbody>
</table>
| **1.** The use of clear glass in bedrooms facing a publicly accessible area. | New | Corrective Action(s): Privacy film will be placed on bedroom windows  
Post-Holder(s) responsible: ADON | Quality & Patient Safety Committee (QPSC) | Yes | 30-9-17 |
| **2.** The presence of broken observation window levers in two single rooms. | New | Corrective Action(s): Present observation windows will be replaced by anti-ligature privacy panels  
Post-Holder(s) responsible: ADON | QPSC | Yes | 31-10-17 |
| **3.** The ability of residents to view opposite-sex residents through an observation room. | New | Corrective Action(s): Blinds will be fitted on the observation room windows  
Post-Holder(s) responsible: ADON | QPSC | | 30-9-17 |

---

^1 Area of non-compliance reoccurring from 2016  
^2 Area of non-compliance new in 2017
## Regulation 22: Premises

Report reference: Page 43 - 44

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>4. Stained tiles and damaged internal walls and floor tiles.</td>
<td>New</td>
<td>Corrective Action(s): Replacement tiles have been ordered and repair of internal walls has been requisitioned Post-Holder(s) responsible: ADON</td>
<td>QPSC</td>
<td>30-11-17</td>
</tr>
<tr>
<td>5. There was no programme of routine maintenance.</td>
<td>New</td>
<td>Preventative Action(s): A programme and schedule for routine maintenance will be established and records kept Post-Holder(s) responsible: ADON</td>
<td>QPSC</td>
<td>31-10-17</td>
</tr>
<tr>
<td>6. Ligature points had not been removed in the en suite bathrooms of single bedrooms.</td>
<td>Reoccurring from 2016</td>
<td>Corrective action(s): Ligature plan in place, works have commenced. Meanwhile, in order to mitigate the risk to residents, each resident’s risk assessment plan will reflect the physical conditions that exist in the APU while works are ongoing. Post-holder(s): ADON</td>
<td>Re-audit of ligature points has been completed and report is currently in preparation.</td>
<td>31-8-17</td>
</tr>
</tbody>
</table>
# Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td>7. The MCRN was not evident on one MPAR.</td>
<td>New</td>
<td>Corrective Action(s): The ECD will advise the Clinical Director of Acute General Hospital of non – compliance and request communication to Medical consultants and NCHDs Post-Holder(s) responsible: ECD</td>
<td></td>
<td>31-8-2017</td>
</tr>
<tr>
<td>8. The start and discontinuation dates and the frequency of administration were not recorded on all MPARs.</td>
<td>New</td>
<td>Preventative Action(s): MCRNs and other required information will be recorded in all MPARS Post-Holder(s) responsible: RCP</td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>New</strong></td>
<td></td>
<td>6 monthly MPARS audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-date medication was found in one of the medication fridges.</strong></td>
<td>New</td>
<td>Corrective Action(s): Weekly checks to ensure medications are in date. Post-Holder(s) responsible: ADON</td>
<td>Regular item in nursing duty list to ensure all medications are in date.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>9. Medication fridges were not clean.</td>
<td>New</td>
<td>Preventative Action(s): Weekly checks to ensure medication fridges are clean Post-Holder(s) responsible: ADON</td>
<td>Regular item in nursing duty list to ensure medication fridges are clean</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>New</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Regulation 26: Staffing

*Report reference: Page 49 - 51*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Reoccurring from 2016. Monitored as per Condition³.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Not all staff had received the required training in BLS, fire safety, the management of aggression and violence, and the MHA (2001).

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³ To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all health care professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Regulation 31: Complaints Procedure

#### Report reference: Page 57 - 58

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
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</table>

#### 12. The five complaints submitted since the 2016 inspection were not appropriately documented.

- Reoccurring from 2016:
  - Preventative Action(s): An updated template is now in place to facilitate appropriate complaint documentation in line with HSE Complaints Management Policy
  - Post-Holder(s) responsible: ADON
  - QPSC
  - Yes
  - Ongoing
## Area(s) of non-compliance

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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>13. There was no written record that all staff had read and understood the policy on the use of physical restraint.</td>
<td>New</td>
<td>Preventative Action(s): A routine practice has commenced whereby staff are required to read and sign off on three policies weekly Post-Holder(s) responsible: ADON</td>
<td>6-monthly audit</td>
<td>Yes</td>
</tr>
<tr>
<td>14. There was no evidence that the use of physical restraint was based on risk assessment.</td>
<td>New</td>
<td>Corrective Action(s): Risk assessment will be documented in all episodes of restraint Post-Holder(s) responsible: ADON</td>
<td>3-monthly audit</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Code of Practice: Admission of Children

**Report reference: Page 73**

<table>
<thead>
<tr>
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| **15. Age-appropriate facilities and activities were not provided.** | New | Corrective Action(s): It is not possible to meet this requirement in an acute adult in-patient setting  
Post-Holder(s) responsible: | Provide the method of monitoring the implementation of the action(s) | Provide details of any barriers to the implementation of the action(s) | Provide the timeframe of the completion of the action(s) | Ongoing |
| **16. The special requirements of the child in an adult setting were not addressed.** | New | Preventative Action(s): A proforma will be developed with a list of all items within the Code Of Practice for the admission of children to be documented by staff on every child admission  
Post-Holder(s) responsible: ADON | 6-monthly audit | Yes | Ongoing |
| **17. The child’s right to have his/her views heard was not documented.** | New | Corrective Action(s):  
Post-Holder(s) responsible | 6-monthly audit | Ongoing |
| | | Preventative Action(s): As per 16. above  
Post-Holder(s) responsible: ADON | | Yes |
Post-Holder(s) responsible: | QPSC | Yes | 30-9-17 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Preventative Action(s): As per 16. above Post-Holder(s) responsible: ADON</th>
<th>6-monthly audit</th>
<th>Yes</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. There was no evidence that the child had his/her rights explained in an accessible manner.</td>
<td>New</td>
<td></td>
<td>6-monthly audit</td>
<td>Yes</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

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## Area(s) of non-compliance

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### 20. The policy did not meet all requirements of the code of practice.

| Reoccurring from 2016 | Corrective Action(s): A resided policy is now in place which meets the requirements of the code of practice | Yes | Completed |
### Code of Practice: Admission, Transfer and Discharge

**Report reference: Page 77 - 78**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>21. The transfer and discharge policies did not meet all requirements of the code of practice.</td>
<td>Reoccurring from 2016</td>
<td>Corrective Action(s): The revised Transfer Policy is now in place which meets the requirements of the code of practice</td>
<td>QPSC</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): The revised Discharge Policy is drafted and has been circulated for feedback and subsequent approval by the QPSC</td>
<td>QPSC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: ECD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. There was no evidence that staff had read and understood the admission and transfer policies.</td>
<td>New</td>
<td>Preventative Action(s): Record of staff who have read and understood the policy will be retained and made available to the MHC</td>
<td>QPSC</td>
<td>Ongoing</td>
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<td>Post-Holder(s) responsible: ADON</td>
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<tr>
<td>23. There was no evidence that an audit had been completed on the implementation of and adherence to the admission and discharge policies.</td>
<td>New</td>
<td>Preventative Action(s): An audit will be undertaken and the findings will be made available to the MHC</td>
<td>QPSC</td>
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<td>Post-Holder(s) responsible: ADON</td>
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