Drogheda Department of Psychiatry

ID Number: AC0099

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Drogheda Department of Psychiatry
Crosslanes
Drogheda
Co Louth

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life

Most Recent Registration Date:
1 September 2016

Conditions Attached:
No

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Dervila Eyres, General Manager,
Mental Health Services, CHO8

Inspection Team:
Dr Enda Dooley MCRN004155, Lead Inspector
Orla O’Neill
Siobhán Dinan
Martin McMenamin

Inspection Date:
5 – 8 September 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
8 – 11 November 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
1 March 2018

2017 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

RATINGS SUMMARY 2016 – 2017

Compliant
Non-compliant
Not applicable
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

**Chart 1 – Comparison of overall compliance ratings 2016 – 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 2016 – 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 approved centre from the register and the prosecution of the registered proprietor.
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 policy and associated guidelines and safety documents in place in relation to the health and safety of residents, staff, and visitors. The approved centre had a written policy available in relation to risk and incident management processes. Structural risks, including ligature points, were effectively mitigated and minimised in the newly built approved centre. There was no emergency plan or emergency evacuation plan in place, which specified responses by the approved centre in relation to possible emergencies.

Resident identifiers were detailed within the residents’ clinical files and checked before staff administered medications, carried out medical investigations, and provided other health care services. Food safety audits were periodically undertaken. Hygiene was maintained to support food safety requirements.

Although ordering and storage of medication was completed in a safe manner, there were deficits in the prescribing and administration of medication. Not all health care professionals were up to date with required training in the areas of fire safety, Basic Life Support, the management of violence and aggression, and the Mental Health Act 2001.

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

The approved centre was non-compliant with Regulation 15 Individual Care Plans. The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. All the therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health
services and be referred to other health services, as required. Not all clinical files were in good order and contained loose pages.

The approved centre complied with the Rules Governing the Use of Seclusion except that one episode of seclusion was not fully documented in the seclusion register. It was compliant with the code of practice on physical restraint. The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because the written record of consent in the clinical file did not contain confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s). In addition, it did not contain any record of supports provided to the patient in relation to the discussion and their decision-making.

Children had been admitted to the approved centre but the approved centre was non-compliant with the relevant code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child residents.

The approved centre was compliant with the majority of the elements of the code of practice with regard to admission, transfer and discharge. However, one resident did not receive a physical examination at the time of admission to the approved centre.

**AREAS REFERRED TO**


**Respect for residents’ privacy and dignity**

All residents’ clothing was clean and appropriate to the residents’ needs. Residents were supported to manage their own property and secure facilities were provided for the safe-keeping of monies, valuables, personal property, and possessions. Resident consent was sought prior to searches and residents were informed by those implementing the search of what was happening during a search and why. Searches were implemented with due regard to the residents’ dignity, privacy and gender.

All residents had their own single rooms. While all observation panels on doors of treatment rooms and bedrooms could be adjusted by staff to provide an opaque glass setting, the dominant default adjustable setting was “open” and residents were unable to close the default setting themselves, which meant that other residents could see into the room. Rooms were overlooked by nearby houses and a new housing development. The current screening did not assure resident privacy. The Adult Acute Unit had a noticeboard, and residents and visitors could potentially identify residents through room numbers and those who were listed as detained. Resident records in the Psychiatry of Old Age Unit were not secure, specifically, in the open space-nurses’ station in the Psychiatry of Old Age Unit, folders containing clinical information could be easily accessed by anyone passing the desk.

Residents were monitored by CCTV solely for the purposes of ensuring their health, safety, and welfare. There were clear signs in prominent positions, which signposted where CCTV cameras were located.
throughout the approved centre. The CCTV cameras were incapable of recording or storing a resident’s image on a tape, disc, or hard drive or in any other format.

### 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 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

### Responsiveness to residents’ needs
Residents were provided with a variety of wholesome and nutritious food choices. The menus were displayed in user-friendly poster format on the noticeboard in the dining room. Residents’ rights to practice religion were facilitated within the approved centre and there was an interdenominational room provided for residents’ religious practices. There was access to multi-faith chaplains.

The approved centre had a separate visiting area to facilitate residents to meet their visitors in private. Residents could use mail, fax, e-mail, telephone, and the Internet if they desired. Residents were provided with an information handbook at admission, and it included all necessary information. The provision of recreational activities was excellent.

Residents had sufficient space to move about and had access to six gardens in the approved centre. Although the approved centre was in good condition, there was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Sitting rooms in the Acute Adult Unit did not provide adequate seating for the number of residents. There were 14 seats between two rooms for 34 residents.

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. There was an excellent complaints procedure in operation.

### 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
Drogheda Department of Psychiatry was part of the HSE Community Health Organisation (CHO) Area 8, providing in-patient services to referrals from counties Meath and Louth. The unit had been open a year and the governance structure was evolving to address the needs of two separate services which had amalgamated.

Seven sector teams from Louth, including two Mental Health Service for Older Persons teams, were responsible for Louth residents in the approved centre and provided in-reach care with weekly multidisciplinary meetings. Meath residents were under the care of a single in-patient consultant while in the approved centre and were transferred back to the care of their community team on discharge. There are concerns about the potential risks posed by having two operating modalities depending on the home address of a resident. It was the consensus of senior management that a single, agreed, operating protocol for the approved centre would be desirable but, to date, it had not proven possible to implement this.
The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. The operating policies and procedures required by the regulations were reviewed within three years with one exception.

**AREAS REFERRED TO**

Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had developed an information leaflet on care planning to better inform residents regarding the process.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

Drogheda Department of Psychiatry was opened in September 2016 and replaced separate acute facilities in Navan and Ardee. The approved centre was located close to but separate from the campus of Our Lady of Lourdes Hospital. It was accessed from a large public car park. The approved centre provided acute in-patient services to counties Louth and Meath. It consisted of 46 beds, of which 38 were for adults (including a 4-bed high observation unit) and 8 were for psychiatry of later life. All bedrooms were single, en suite rooms. All resident accommodation was located on the ground floor, while office and staff facilities were located on the first floor.

Seven sector teams from Louth, including two Mental Health Service for Older Persons (MHSOP) teams, were responsible for Louth residents in the approved centre and provided in-reach care with weekly multidisciplinary meetings. Meath residents were under the care of a single in-patient consultant while in the approved centre and were transferred back to the care of their community team on discharge.

The resident profile on the first day of inspection was as follows:

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>46</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>44</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>10</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>1</td>
</tr>
<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>11</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

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

Drogheda Department of Psychiatry was part of the HSE Community Health Organisation (CHO) Area 8, providing in-patient services to referrals from counties Meath and Louth. The unit had been open a year and the governance structure was evolving to address the needs of two separate services which had amalgamated.

Minutes of a number of working groups dealing with various aspects of operational and clinical governance within the approved centre were provided to the inspection team. These included the Multi-disciplinary Executive Management Team (MEMT), which met monthly; the Clinical Governance Committee; the Operational Group; the Site Safety Management Team; and the Nurse Education and Policy Development Committee. These subordinate groups reported in a hierarchical fashion to the MEMT.

Among the issues pertaining to the approved centre and addressed at these meetings were staffing, procedures for organising an admission pathway to the approved centre, risk issues affecting the approved centre, and coordination of community structures relating to the approved centre. Review of the minutes of these various committees indicated an active and comprehensive governance process, which involved staff from various disciplines.
## 5.0 Compliance

### 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 8 – 11 November 2016 identified the following areas that were non-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 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>Non-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:

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2016 Compliance</th>
<th>2017 Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act (2001): Consent To Treatment</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children under the Mental Health Act 2001</td>
<td>Not Applicable</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>X</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>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>X</td>
</tr>
</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

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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 inspectors met with six residents on an individual basis. A variety of issues of concern were raised including communication difficulties with staff, lack of access to outdoor areas, lack of adequate processes for mobile phone charging, and inadequate shower temperature in certain bedrooms. These matters were brought to the attention of management.

The inspectors also met with the IAN representative who provided a detailed account of issues concerning residents. The area lead for service users and carers met with the inspectors and outlined her role. She was a designated member of the Multi-disciplinary Executive Management Team.
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:

- Executive Clinical Director
- Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker

The Principal Psychologist was unable to meet the inspection team.

The team also met with the Quality and Patient Safety Manager.

The various clinical discipline heads of service outlined their involvement in the overall governance process. Issues raised consistently were concern about risks posed by a lack of adequate and structured in-patient bed access, difficulties in ensuring maintenance of required training, and problems in maintaining required staff numbers. Concerns were expressed across the disciplines at the potential risks posed by having two operating modalities (outlined in 4.1 above) depending on the home address of a resident. It was the consensus of senior management that a single, agreed, operating protocol for the approved centre would be desirable.
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:

- Executive Clinical Director (ECD)
- Registered Proprietor Representative
- Area Director of Nursing
- Senior Occupational Therapist (representing OT Manager)
- Clinical Psychologist (representing Principal Psychologist)
- Social Worker (representing Principal Social Worker)
- Quality and Risk Manager
- Assistant Director of Nursing
- CNM3 x 2
- CNM2
- Consultant Psychiatrist
- Business Manager
- Service User Area Lead
- Mental Health Act Administrator

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. It was clarified that the public phone in the approved centre was now working. The ECD clarified that a child was only admitted after all potential suitable alternatives were exhausted and that the admission of a child would only be as a last resort for the shortest time possible.

It was explained that the approved centre was in the process of obtaining a HSE overview and review of their operating modalities (see 4.1 above) with a view to deciding and implementing one single operating modality across both Louth and Meath for the admission and management of residents within the approved centre.
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 policy dated May 2017 on the identification of residents. The policy included requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities in relation to the identification of residents.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on the identification of residents. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit was undertaken to ensure there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving resident identification processes.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile were used. The identifiers were detailed within the residents’ clinical files and checked before staff administered medications, carried out medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre used three person-specific resident identifiers: photograph, addressograph, and wristband. The identifiers were appropriate to the residents’ needs and communication abilities. There was a red sticker alert system in place for staff to distinguish between 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 processes pillar.
### Regulation 5: Food and Nutrition

| COMPLIANT | Quality Rating | Satisfactory |

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident’s individual care plan.

### INSPECTION FINDINGS

**Processes:** The approved centre had a policy on food and nutrition, dated September 2016. The policy included the requirements of the *Judgement Support Framework*, with the exception of the process for **monitoring** food and water intake.

**Training and Education:** Relevant staff had signed a log to indicate that they had read and understood the policy on food and nutrition. Relevant staff interviewed were able to articulate the processes relating to food and nutrition, as set out in the policy.

**Monitoring:** A systematic review of menu plans was conducted every month to ensure that residents were provided with wholesome and nutritious food suitable to their needs. Documented analysis was completed by the Food and Nutrition Committee to enhance the food and nutrition processes.

**Evidence of Implementation:** The approved centre’s menus had regular input from and had been reviewed and approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ dietary needs. The speech and language therapist also had input into menu planning, and there was a three-week menu cycle.

Residents were provided with a variety of wholesome and nutritious food choices. The menus were displayed in user-friendly poster format on the noticeboard in the dining room. Hot meals were served daily in a bright and spacious dining room. Meals were attractively presented. Both hot and cold drinks were offered regularly. Residents had adequate supplies of safe and fresh drinking water in easily accessible locations throughout the approved centre.

The needs of residents identified as having special nutritional requirements were reviewed weekly by a dietitian, on a referral basis. An evidence-based nutritional assessment tool, the Malnutrition Universal Screening Tool (MUST), was used for residents with special dietary needs. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in the residents’ individual care plans.

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 pillar.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place on food safety, dated September 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented.

Monitoring: Food temperatures were recorded in line with food safety recommendations. A log sheet, which was kept in the approved centre’s kitchen, was maintained and monitored. Food safety audits were periodically undertaken. Documented analysis was completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery to meet the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
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, dated May 2017, in relation to residents’ clothing. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all relevant staff had signed a log to indicate that they had read and understood the policy on residents’ clothing. Only two staff members had signed. Relevant staff interviewed were able to articulate the processes for residents’ clothing, as set out in the policy.

**Monitoring:** The availability of an emergency supply of clothing for residents was monitored on an ongoing basis.

**Evidence of Implementation:** Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans. They were provided with appropriate emergency personal clothing that took into account their preferences, dignity, bodily integrity, and religious and cultural practices. In-patient laundry facilities were provided, and all residents’ clothing was clean and appropriate to the residents’ needs.

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 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated April 2016 relating to residents’ personal property and possessions. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read understood the policy on residents’ personal property and possessions. Relevant staff interviewed articulated the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were maintained, and monitored in the approved centre. Documented analysis was completed to identify opportunities to improve the processes for managing residents’ personal property and possessions.

Evidence of Implementation: The approved centre maintained a signed property checklist detailing each resident’s personal property and possessions. The property checklist was kept distinct from the resident’s individual care plan (ICP). Residents were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their ICPs. Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. All property was stored securely in large, and clearly-labelled clear plastic boxes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy dated September 2016 in relation to the provision of recreational activities. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on recreational activities. Relevant staff interviewed were able to articulate the recreational activities processes, as set out in the policy.

Monitoring: There was a record of the occurrence of planned recreational activities, including a record of resident uptake and attendance. Documented analysis had been completed to identify opportunities to improve the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and at the weekend. Residents had opportunities to share their unique perspectives and contribute ideas to recreational activities development, at the weekly community meeting.

Information on recreational activities was in a semi-accessible format through a timetable, which was displayed on a whiteboard. The whiteboard was positioned on the dining room corridor, and residents had to read it through the door window because the door on the corridor was closed at the time of the inspection due to an individual risk assessment. Information on recreational activities was also displayed in the information room, but not all residents had access to this room.

The approved centre had outdoor gym equipment, located in each of the four gardens, for residents to use. Communal spaces were available throughout the approved centre, which were suitable for recreational activities. The approved centre had a dedicated recreation room, garden areas, group rooms, television lounge areas and an information area. It also had a pool table, table tennis, badminton set, televisions, radios, books, board games, daily newspapers, garden walkways, MP3 players, Internet stations, and game console equipment. Attendance at recreational activities was documented in each resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was excellent because the approved centre met all criteria of the Judgement Support Framework.
### Regulation 10: Religion

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

#### INSPECTION FINDINGS

**Processes:** The approved centre had a policy in place, dated August 2016, on the facilitation of religious practices. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed a log to indicate that they had read and understood the policy on religion. Relevant staff interviewed could articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

**Monitoring:** The implementation of the policy to support residents’ religious practices had been reviewed to ensure that it reflected the identified needs of the residents.

**Evidence of Implementation:** Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable, and there was an interdenominational room provided for residents’ religious practices. A deacon visited weekly on Friday mornings. Residents had access to multi-faith chaplains, and they were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services provided within the approved centre were respectful of the residents’ religious beliefs and values.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.
Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated September 2017, and protocols in place in relation to visits. The policy and protocols included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on visits. Relevant staff interviewed could articulate the processes for visits, as set out in the policy.

Monitoring: At the time of the inspection, there were no restrictions on residents’ rights to receive visitors. Documented analysis of the processes relating to visits had not been completed.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed. The approved centre had a separate visiting area to facilitate residents to meet their visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Residents and visitors’ safety was assured during visits. Children could visit, if accompanied by an adult and supervised at all times. The visiting facilities available were 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 met not all criteria of the Judgement Support Framework under the training and education and monitoring 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 a written operational policy, dated October 2016 in relation to communication. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on communication. Relevant staff interviewed articulated the processes for communication, as set out in the policy.

Monitoring: Residents’ communication needs and restrictions on communication were monitored on an ongoing basis and recorded in their clinical files. Analysis had not been undertaken to identify opportunities to improve the communication processes.

Evidence of Implementation: Residents could use mail, fax, e-mail, telephone, and the Internet if they desired. The public phone had no dial tone on days two and three of the inspection because residents had disconnected a cable and that this had been reinserted.

The approved completed individual resident risk assessments, when necessary, in relation to any risks associated with residents’ external communications; these were documented in each resident’s individual care plan and in risk assessment documentation. Relevant senior staff only examined incoming and outgoing resident communication if there was cause to believe that the communication may result in harm to the resident or others.

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 monitoring pillar.
Regulation 13: Searches

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident’s dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

Processes: There were two written policies (dated March 2014 and September 2016) available in relation to the searching of a resident, his or her belongings, and the environment in which he or she was accommodated. The policies, combined, included all of the requirements of the Judgement Support Framework, including

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

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policies on searches. Relevant staff interviewed were able to articulate the searching processes, as set out in the policies.

Monitoring: A log of searches was maintained and each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. Documented analysis was completed to identify opportunities for improvement of the search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. There had been no environmental searches since the last inspection. Four clinical files and search forms were inspected in relation to searches. Risk had been assessed prior to the search of a resident or their property, appropriate to the type of search being undertaken. Resident consent was sought prior to all four searches, and residents’ consent was documented in the search forms.
Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the residents’ dignity, privacy and gender; at least one of the staff members who was conducting the search was the same gender as the resident being searched.

A written record of every search of a resident and every property search was available (i.e. a record of the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search). Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated May 2017, in relation to care of the dying. The policy included requirements of the Judgement Support Framework, with the following exception:

- The involvement, accommodation and support provided to resident representatives, family, next of kin and friends during end of life care.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy and protocols on care of the dying. Relevant staff interviewed could articulate the processes for end of life care, as set out in the policy.

One resident of the approved centre died while on leave from the centre and this death was notified to the Mental Health Commission within the specified time period. No deaths had occurred within the approved centre since the last inspection.

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 had a policy in place on individual care planning, dated January 2015. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log to indicate that they had read and understood the policy on care planning. All clinical staff interviewed could articulate the processes relating to individual care planning, as set out in the policy. There was no evidence that all multi-disciplinary team (MDT) members were trained in individual care planning.

Monitoring: Individual care plans (ICPs) were audited on a quarterly basis to assess compliance with the regulation. Analysis was completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: Twenty-one ICPs were inspected. They were stored as a composite set of documents. Each resident was assessed at admission. An initial care plan was completed by the admitting clinician to address the immediate needs of the residents. In two cases, ICPs were not developed within seven days of admission. In five cases, ICPs reviewed were developed by nursing and medical staff only and were not developed by the MDT.

The ICP was discussed, agreed, and where practicable drawn up with the participation all residents. However, five ICPs were not signed by the resident. In nine ICPs, there was no evidence of family involvement. Appropriate goals were not identified in three care plans. One ICP did not identify the resources required to provide the care and treatment identified. When a resident declined or refused a copy of their ICP, this was recorded. In four cases, however, the refusal reason was not recorded.

The approved centre was non-compliant with this regulation for the following reasons:

a) Two ICPs were not developed within seven days of admission.

b) In five cases, ICPs reviewed were developed by nursing and medical staff only and were not developed by the MDT.

c) Three ICPs did not identify appropriate goals.

d) One ICP did not identify the resources required to provide the care and treatment identified.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to therapeutic services and programmes, dated September 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log to indicate that they had read and understood the policy on therapeutic services and programmes. All clinical staff interviewed were able to articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The occupational therapy department monitored the range of available therapeutic services and programmes on an ongoing basis to ensure that they met the assessed needs of residents. Residents evaluated the programmes on an evaluation sheet when they attended the groups. Documented analysis was completed to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents, as documented in the residents’ individual care plans (ICPs).

All the therapeutic programmes and services were provided by staff trained in accordance with their care delivery roles and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Available groups included relaxation, art therapy, cognitive stimulation therapy for the Psychiatry of Old Age unit, and an artisans group. Psychoeducational groups included a “how to use my care plan” group, a 1 to 1 session, and sessions on independent living skills and were given by the occupational therapy department. Adequate resources and facilities were available.

A list of therapeutic services and programmes provided within the approved centre was available to residents via a weekly schedule of activities posted up on a noticeboard. The location of the noticeboard was not easy for all residents to access. Therapeutic services and programmes were provided in a separate dedicated room, which was appropriate for the delivery of both individual and group therapies.

Where a resident required a therapeutic service or programme that was not provided internally, such as yoga or art therapy, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes within each resident’s 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 pillar.
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

Three children had been admitted to the approved centre since the last inspection. None of the three children had a requirement for educational input. Therefore, 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 operational policy dated May 2017 in relation to the transfer of residents. The policy detailed all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on transfers. Relevant staff interviewed articulated the processes for the transfer of residents, as outlined in the policy.

Monitoring: A transfer log was maintained. Each transfer record was systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis was not completed to improve information provision during transfers.

Evidence of Implementation: No current resident had been transferred to another health care facility. The clinical file of a recently discharged patient who had been transferred to another health care facility was inspected. A Form 10 (Notice of Patient Transfer to Another Approved Centre) was completed by the approved centre. The patient was detained, and the patient’s agreement to the planned transfer was documented.

Communications between the approved centre and the receiving facility were documented and followed up by a written referral. Prior to transfer, the resident was assessed; this assessment included an individual risk assessment relating to the transfer and an assessment of the resident’s needs.

Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the receiving facility. The clinical file recorded the documentation released to the receiving facility as part of the transfer, including the letter of referral, a list of current medications, the resident transfer form, and the required medication for the resident during the transfer process. The approved centre completed checks to ensure comprehensive resident records were transferred to the receiving facility.

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 monitoring pillar.
Regulation 19: General Health

Compliant
Quality Rating Satisfactory

(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 operational policies and procedures for responding to medical emergencies, dated September 2015 and in relation to general health, dated June 2016. The policies, combined, included the requirements of the Judgement Support Framework, with the following exceptions:

- The medical emergency policy did not include the roles and responsibilities for responding to medical emergencies and the management of emergency response equipment, including the resuscitation trolley and Automated External Defibrillator (AED).
- The general health services policy did not include the resource requirements for general health services, including equipment needs; the protection of resident privacy and dignity during general health assessments; and the referral process for general health needs of residents.

Training and Education: Not all clinical staff had signed a log to indicate that they had read the policies on the provision of general health services and for responding to medical emergencies. All clinical staff interviewed were able to articulate the processes for the provision of general health services and for responding to medical emergencies, as set out in the policies.

Monitoring: Resident take-up of national screening programmes was recorded and monitored, where applicable. Documented analysis was completed to identify opportunities to improve general health processes. A systematic review to ensure six-monthly reviews of general health needs were completed took place.

Evidence of Implementation: Appropriate arrangements were in place within the approved centre to deal with medical emergencies. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, but not less than every six months. Clinical testing results were documented. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Information and access was provided to residents in relation to national screening programmes.

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 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:
   
   (a) details of the resident’s multi-disciplinary team;
   
   (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
   
   (c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
   
   (d) details of relevant advocacy and voluntary agencies;
   
   (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: There as a written operational policy, dated March 2016, and procedures available in relation to the provision of information to residents. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed a log to indicate that they had read the policy on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as mapped out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure the information was appropriate and accurate, particularly where information changed, such as information on medication and housekeeping practices. Documented analysis was not completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents were provided with an information handbook at admission, and it included all necessary information on housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents’ rights. In addition, residents were provided details of their multi-disciplinary team (MDT) at admission.

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. Medication information sheets, as well as verbal information, was provided to residents in a format that was aligned with the residents’ needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

The approved centre had a designated information area where residents could access information relating to diagnosis. Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition.
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.
The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a policy, dated May 2017, in relation to privacy. The policy included requirements of the *Judgement Support Framework*, with the exception of the approved centre’s process to be applied where resident privacy and dignity were not respected by staff.

**Training and Education:** All staff had signed a log to indicate that they had read and understood the policy relating to resident privacy. All staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

**Monitoring:** A documented annual review was undertaken to check that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis was completed to identify opportunities to improve the processes relating to residents’ privacy and dignity.

**Evidence of Implementation:** Staff were seen to be professional and respectful when interacting with residents. They wore clothes which respected the privacy and dignity of residents. All residents had their own single rooms. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

While all observation panels on doors of treatment rooms and bedrooms could be adjusted by staff to provide an opaque glass setting, the dominant default adjustable setting was “open” and residents were unable to close the default setting themselves, which meant that other residents could see into the room. Rooms were overlooked by public areas. The gardens in the Psychiatry of Old Age and Adult Acute units remained overlooked by nearby houses and a new housing development. The current screening did not assure resident privacy. Noticeboards did not detail resident names but did include other identifiable information. The Adult Acute Unit had a noticeboard and residents and visitors could potentially identify residents through room numbers and those who were listed as detained. Residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because resident’s privacy and dignity were not appropriately respected at all times for the following reasons:

(a) Rooms were overlooked by public areas.
(b) Residents could be identified by other residents and visitors from noticeboards.
(c) Residents were unable to ensure the privacy of their personal bedrooms from external observation.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a policy in place, dated May 2017, in relation to the premises. This policy included requirements of the Judgement Support Framework, with the exception of the approved centre’s utility controls and requirements.

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

Monitoring: The approved centre had completed a ligature audit. A hygiene audit had not been completed. Documented analysis had been completed to identify opportunities to improve the premises.

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. However; residents were unable to control heating in their own bedrooms. All residents had access to personal space, and each had their own single room with en suite facilities. Residents had sufficient space to move about and had access to six gardens in the approved centre. There were enough toilets and showers for residents. Ligature points were minimised.

A number of doors in the approved centre leading to gardens and external areas were difficult to open and close with the potential for residents to be unable to get in again easily. One door was not fully shut at the time of the inspection and could potentially have been a route for residents to leave the unit by climbing the steel staircase which led to the roof area.

The opaque glass door to the garden area, at the end of the main corridor in the acute adult unit, did not have a push button mechanism to facilitate wheelchair users.
There was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Sitting rooms in the Acute Adult Unit did not provide adequate seating for the number of residents. There were 14 seats between two rooms for 34 residents. This meant the approved centre did not provide suitable furnishings to support resident independence and comfort.

The approved centre was non-compliant with this regulation for the following reasons:

- a) It did not have a programme of routine maintenance, 22.1(c).
- b) It did not have adequate and suitable furnishings for the number and mix of residents in the approved centre, 22.2.
- c) The potential for residents to access the roof was contrary to the requirements of 22.3.
(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 written operational policy in place, dated May 2017, in relation to the ordering, prescribing, storing and administration of medicines. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The process to be applied when medication was refused by the resident.
- The process for medication management at admission, transfer, and discharge.
- The process to review resident medication.
- The process for medication reconciliation.

Training and Education: All nursing and medical staff had signed a log to indicate that they had read and understood the policy. All nursing, medical and pharmacy staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administration of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical and pharmacy staff in the approved centre received training on the importance of reporting medication incidents, errors or near misses, and this was documented.

Monitoring: Quarterly audits had been conducted on the 14 Medication Prescription and Administration Records (MPARs) inspected. Incident reports were recorded for medication errors and near misses. Analysis had been completed to identify opportunities for improvement of medication management processes.

Evidence of Implementation: Each resident had an MPAR, with two appropriate resident identifiers. The Medical Council Registration Number of every medical practitioner prescribing the medication was included in all cases. A record was kept when medication was refused by or withheld from a resident. Medication was stored in the appropriate environment. The medication trolley remained locked at all times, and secured in a locked room.

The following discrepancies were found on inspection:

- Three MPARs did not record the generic name of the medication and preparation.
- Five MPARs did not record any medications refused by the resident, which meant the medication omission code was not recorded on the administration chart for staff to read.
- A clear record of the date of discontinuation for each medication was not recorded in five cases attached to MPARs.
- One dose of medication was administered after its recorded stop date and was not, therefore, administered in accordance with the directions of the prescriber.
- Withheld medication and the justification for withholding the medication was not documented in five prescriptions contained in the MPAR and the clinical file.
The approved centre was non-compliant with this regulation for the following reasons:

a) Three MPARs did not record the generic name of the medication preparation, 23 (1).
b) Five MPARs did not record any medications refused by the resident, which meant the medication omission code was not recorded on the administration chart for staff to read, 23 (1).
c) A clear record of the date of discontinuation for each medication was not recorded in five prescriptions attached to MPARs, 23 (1).
d) One dose of medication was administered after its recorded stop date and was not, therefore, administered in accordance with the directions of the prescriber, 23 (1).
e) Withheld medication and the justification for withholding the medication was not documented in five prescriptions contained in the MPAR and the clinical file, 23 (1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: There was a written policy (dated August 2016) and associated guidelines and safety documents in place in relation to the health and safety of residents, staff, and visitors. The policy and associated documents included requirements of the Judgement Support Framework, with the exception of two infection control measures: linen handling, and the availability of staff vaccinations and immunisations.

Training and Education: All staff had signed a log to indicate that they had read and understood the health and safety policy. Staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy and associated documents.

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

Processes: There was a policy dated May 2017, and procedures in the approved centre on the use of CCTV. The CCTV policy was dated May 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff interviewed were able to articulate the processes relating to the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images was checked regularly to ensure they were operating appropriately, and this was documented. An audit and analysis was completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: The Mental Health Commission had been informed about the approved centre’s use of CCTV. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. There were clear signs in prominent positions, which signposted where CCTV cameras were located throughout the approved centre.

One CCTV monitor was in an enclosed screen in the nursing office, at the main entranceway to the approved centre. A second CCTV monitor was in the seclusion room annex. Neither of these transmitted images other than to a monitor that was viewed solely by the health professional responsible for the resident, i.e. clinical and nursing staff. The CCTV cameras were incapable of recording or storing a resident’s image on a tape, disc, or hard drive or in any other format.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 26: Staffing

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

INSPECTION FINDINGS

Processes: The approved centre had a policy on staffing, dated June 2016. It set out the roles and responsibilities for the recruitment of staff and the appointment processes for all staff within the approved centre. The roles and responsibilities in relation to staff training processes, and the approved centre’s recruitment, selection, and vetting processes were detailed in the policy.

The policy did not include the following requirements of the Judgement Support Framework:

- The staff performance and evaluation requirements.
- The process for transferring responsibility from one staff member to another.

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

Monitoring: There was no documentary evidence to indicate that the implementation and effectiveness of staff training plans were reviewed on an annual basis. The number and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Documented analysis was not completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: The approved centre had an organisational chart, which identified the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. A planned and actual staff rota, showing the staff on duty at any one time in the approved centre, was maintained. The number and skill mix of staffing was sufficient to meet resident needs.

Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment of staff. All staff, including permanent, contract, and volunteers, were vetted in accordance with the HSE’s national recruitment policy. Staff had appropriate qualifications to do their job. An appropriately qualified staff member was on duty and in charge at all times.
A staffing plan for the approved centre, outlining currently agreed numbers by discipline was provided. Annual staff training plans were completed for staff to identify required training and skills development in line with the assessed needs of the resident group.

Not all health care professionals were trained in the following:

- Fire safety.
- Basic Life Support.
- The management of violence and aggression.
- The Mental Health Act 2001.

Staff had completed training in various areas including manual handling, dementia care, care for residents with an intellectual disability, infection control and infection prevention, risk management, incident reporting and the protection of children and vulnerable adults. At least one staff member was trained in Children First. All staff training was documented. Staff training logs were maintained. Opportunities were made available to staff for further education. Where available, in-service training was completed by trained and competent individuals. Facilities and equipment were available for staff in-service education, and training.

The Mental Health Act 2001, the associated regulation (S.I. No 551 of 2006), and the Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were made available to staff through the approved centre.

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>CNM3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CNM2</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CNM1</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>RPN</td>
<td>12</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>HCA</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice. Not all health care professionals were up to date with required training in the areas of fire safety, Basic Life Support, the management of violence and aggression, 26 (4) and the Mental Health Act 2001, 26(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 operational policy dated July 2014 in relation to the maintenance of records. The policy included requirements of the Judgement Support Framework, with the exception of the required resident record content and the record review requirements.

Training and Education: Not all clinical staff and other relevant staff had signed the log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed could articulate the processes for the creation of, access to, retention of, and destruction of records, as described in the policy. Not all clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis was completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: Records were maintained through the use of an identifier unique to the resident. Entries on residents’ records were factual and consistent, and each recorded the date and time using the 24-hour clock. Hand-written records were legible and written in black ink. All resident records were physically stored together where possible. Residents’ access to their records was managed in accordance to the Data Protection Acts. All residents’ records were up-to-date. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

All clinical files were not in good order because six files contained loose pages. Resident records in the General Adult Unit and High Observation Unit were secure. However, resident records in the Psychiatry of Old Age Unit were not secure, which meant these records could potentially be tampered with, or accessed without authorisation. Specifically, in the open space-nurses’ station in the Psychiatry of Old Age Unit, folders containing clinical information such as National Incident Management System forms, therapeutic risk assessments, and individual care plans could be easily accessed by anyone passing the desk.

The approved centre was non-compliant with this regulation because:
   a) Not all records were maintained in good order -six files contained loose pages, 27(1).
   b) All records and reports were not kept in a safe secure place.
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 available to the Mental Health Commission on inspection. The register included information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006, with the following exceptions: Residents’ address, next of kin/representatives, diagnosis date, and diagnosis on discharge were not detailed on the register.

The approved centre was non-compliant with this regulation because the register of residents did not contain all of the information required under Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Residents’ address, next of kin/representatives, diagnosis date, and diagnosis on discharge were not detailed on the register, 28 (1).
The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy, dated May 2016, in relation to the development, management, and review of operating policies and procedures. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed a log to indicate that they had read and understood the policy on developing and reviewing operating policies. Relevant staff were trained on approved operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

**Monitoring:** An annual audit had been undertaken to determine compliance with review time frames. Analysis of operating policies and procedures was conducted to identify opportunities to improve the processes for developing and reviewing policies.

**Evidence of Implementation:** The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. The approved centre had a written statement adopting generic policies, where appropriate. The statement was reviewed every three years. Any generic policies used were appropriate to the approved centre and the resident group profile. The operating policies and procedures required by the regulations were reviewed within three years with one exception - the policy in relation to Regulation 27 Maintenance of Records was out of date.

The approved centre was non-compliant with this regulation because Regulation 27: Maintenance of Records had not been reviewed within the stipulated three-year period and was, therefore, out of date.
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 had a policy in place on Mental Health Tribunals, dated September 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All relevant staff had signed a log to indicate that they had read and understood the policy on Mental Health Tribunals. Relevant staff were able to articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Documented analysis was completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided facilities and adequate resources to support the Mental Health Tribunals process. The dedicated tribunal room was located in the main foyer, front reception. A legal representative room was also available, and the Mental Health Act Administrator’s room was located next door. Nursing staff accompanied and assisted patients to attend a tribunal, when necessary.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated January 2017 in relation to the management of complaints. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff were trained in the complaints management process during their induction. All staff had signed a log to indicate that they had read and understood the policy on complaints. 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 and related records was completed, with findings documented and acted upon. Complaints data were analysed, discussed, and considered by senior management, with required actions identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer, who was responsible for dealing with all complaints and was available to the approved centre. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. Residents were provided with the complaints policy and procedure within an information booklet, at admission or soon thereafter.

The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint can be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.
All complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 32: Risk Management Procedures

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy dated May 2017 available in relation to risk and incident management processes. The policy included all of the policy-related regulatory requirements and all of the Judgement Support Framework requirements, with one exception: the process for responding to specific emergencies, including the roles and responsibilities of key staff, the sequence of required actions, the process for communication, and the escalation of emergencies to management.

Training and Education: Not all training was documented. There was no documented evidence of any staff being trained in the identification, assessment, and management of risk or in health and safety risk management. Clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. Only 31 staff were trained in incident reporting and documentation. Not all staff had signed a log to indicate that they had read and understood the risk management policy. Not all staff interviewed were able to articulate the risk management processes, as set out in the policy.

Monitoring: All incidents in the approved centre were recorded and risk-rated. The risk register was audited to determine compliance with the approved centre’s risk management policy. Documented analysis of incident reports to identify opportunities for the improvement of risk management processes was completed.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Clinical, health and safety, and corporate risks were identified, assessed, treated, monitored, and recorded in the risk register. Structural risks, including ligature points, were effectively mitigated and minimised in the newly built approved centre.
Incidents were recorded and risk-rated in a standardised format through the National Incident Management System. Clinical incidents were reviewed by the multi-disciplinary team at its regular meeting. A six-monthly summary of incidents was provided to the Mental Health Commission in line with the Code of Practice on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level.

There was no emergency plan or emergency evacuation plan in place, which specified responses by the approved centre in relation to possible emergencies. The requirements for the protection of children and vulnerable adults from abuse within the approved centre were appropriate and implemented as required.

The approved centre was non-compliant with this regulation because it did not have an emergency evacuation plan in place, 32(e).
Regulation 33: Insurance

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

INSPECTION FINDINGS

The approved centre had up-to-date insurance. It indicated that cover was provided under the umbrella 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

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

The approved centre was compliant with this regulation.
10.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)
### Section 59: The Use of Electro-Convulsive Therapy

**NOT APPLICABLE**

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 Electro-Convulsive Therapy was not used in the approved centre, 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 contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated May 2017, on the use of seclusion. A separate policy and procedures were in place on training staff in the use of seclusion, and there was a policy regarding the use of CCTV. The policies included all requirements specified in the Rules Governing the Use of Seclusion.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the current policies. A record of training was maintained.

Monitoring: There was a documented annual report on seclusion the use of seclusion.

Evidence of Implementation: There was one seclusion room in the approved centre, which had not been used as a bedroom. The seclusion room was furnished, maintained, and cleaned to ensure resident dignity, privacy, and safety. The seclusion suite had a toilet and washing facility. The clinical files of three residents who had been secluded were inspected. Seclusion had been used in rare and exceptional circumstances to ensure the safety of the residents and others. There was a CCTV camera in the seclusion room and CCTV viewing was restricted to designated personnel. The approved centre complied with the Rules Governing the Use of Seclusion across all three episodes, with one exception: In one episode data regarding the initiation process was not fully recorded in the seclusion register.

The approved centre was non-compliant with the Rules Governing the Use of Seclusion because
   a) one episode of seclusion was not fully documented in the seclusion register, 9.1;
   b) Not all relevant staff had signed the log to confirm that they had read and understood the policy, 10.2 (b).
**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 restraint was 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

Processes: At the time of the inspection, two clinical files were inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. One patient was assessed as capable of consenting and had agreed to receiving treatment. The written record of consent in the patient’s clinical file did not contain confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s) prescribed. In addition, it did not contain any indication of supports requested by or provided to the patient to assist in the patient’s decision on whether or not to receive treatment.

The clinical file did contain a record of the patient’s consent with a written record of the name of specific medications prescribed.

Details were provided of discussion with the patient, including:

- The nature and purpose of the medication(s).
- The effects of medication(s), including risks and benefits and views expressed by the patient.
A second patient did not have capacity to consent to treatment, and the patient had refused to consent to treatment. A Form 17 (Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent) had been completed for the patient as required.

The Form 17 was stored within the clinical file and contained the following information:

- The names of the medication prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose and likely effects of the medication(s).
  
  Details of any discussion with the patient, including
  - The nature and purpose of the medication(s).
  - The effects of the medications(s), including any risks and benefits.
  - Any views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
  - Authorisation by a second consultant psychiatrist.

The approved centre was non-compliant with Part 4: Consent to Treatment because the written record of consent in the clinical file did not contain confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s). In addition, it did not contain any record of supports provided to the patient in relation to the discussion and their decision-making, 56(b).
12.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy in place dated May 2017 in relation to the use of physical restraint, and it was reviewed annually. There was a separate policy and procedures in relation to staff training in the use of physical restraint. The policies included all of the policy-relevant guidance criteria of this code of practice.

Training and Education: The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy. A record of attendance at training was maintained. Physical restraint was not used to ameliorate staff shortages.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: The clinical files of five residents who had been physically restrained were inspected. The approved centre complied with the code of practice on physical restraint across all episodes. Restraint was implemented in the residents’ best interests, and in rare and exceptional circumstances where the resident posed an immediate threat of serious harm to self or others. Staff had considered all other interventions to manage the patient’s unsafe behaviour in advance of implementing physical restraint.

The approved centre was compliant with this code of practice.
Admission of Children

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

INSPECTION FINDINGS

Processes: The approved centre had policy, dated September 2016, and protocols in place in relation to the admission of a child. There was a policy requiring each child to be individually risk assessed. A policy and procedures were in place with regard to family liaison, parental consent, and confidentiality.

Training and Education: Fourteen staff had received up-to-date Children First training.

Monitoring: An audit was not undertaken to monitor the admission of children processes.

Evidence of Implementation: The approved centre was not a child and adolescent approved centre, and age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child residents. The clinical files of three children who had been admitted to the approved centre since the last inspection was inspected.

Provisions were in place to ensure the safety of each child and to respond to a child’s particular needs as a young person in an adult setting. The children did not have access to age-appropriate advocacy services as there are none for approved centre facilities that are not privately owned. The children were given information on their rights.

In relation to child protection issues, staff having contact with the children had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated and was arranged according to age and gender, including sleeping arrangements and bathroom areas. Staff were gender sensitive.

Appropriate visiting times for families, including children, were available. The Mental Health Commission was notified of the child admitted to the approved centre for adults within 72 hours using the appropriate notification form. Consent for treatment was obtained from at least one parent.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child residents, 2.5(b).
Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

**INSPECTION FINDINGS**

**Processes:** There was a risk management policy, dated May 2017, which covered the notification of deaths and incident reporting to the Mental Health Commission. The policy included all elements of section 4 of this code of practice.

**Training and Education:** Staff had signed a log to indicate that they had read and understood the policy on the notification of deaths and incidents. Staff interviewed were able to articulate the policy.

**Monitoring:** Deaths and incidents were reviewed to identify and correct any problems as they arose and to improve quality. A six-monthly summary of all incidents was provided to the Mental Health Commission.

**Evidence of Implementation:** The approved centre was non-compliant with Article 32 of the regulations. The National Incident Management System was in use. A standardised incident report form was used and made available to inspectors. There had been one death in the approved centre since the last inspection and it was notified to the Mental Health Commission within 48 hours.

The approved centre was non-compliant with this code of practice because it was non-compliant with Article 32 of the regulations.
Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

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

INSPECTION FINDINGS

Processes: There were policies and protocols in place for staff working with people with intellectual disabilities. The policies reflected person-centred treatment planning and presumption of capacity. Least restrictive interventions, staff roles and responsibilities, and the management of problem behaviours were detailed in the policy. There was no policy in relation to the training of staff in working with people with an intellectual disability.

Training and Education: Staff were trained in working with people with intellectual disabilities. The education and training provided supported the principles and guidance material in the code of practice. Person-centred approaches, relevant human rights principles, and preventative and responsive strategies to problem behaviours were covered by the training and education delivered.

Monitoring: The policies were reviewed every three years. The use of restrictive practices was reviewed periodically in accordance with the approved centre’s policy.

Evidence of Implementation: As there was no resident with an intellectual disability in the approved centre at the time of the inspection, the evidence of implementation pillar was not applicable. The approved centre was assessed under the processes, training and education, and monitoring pillars only.

The approved centre was non-compliant with this code of practice because there was no policy in relation to the training of staff in working with people with an intellectual disability, 6.2.
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 Electro-Convulsive Therapy was not used in the approved centre, 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: There were up-to-date policies on admission, transfer, and discharge in place. The policies included the policy-relevant code of practice items stipulated, with the exception of the following: The discharge policy did not reference a way of following up and managing missed appointments.

Training and Education: There was no documented evidence to suggest that staff had read and understood the admission policy. Not all staff had signed a log to indicate that they had read and understood the policies on transfer and discharge.

Monitoring: An audit of the implementation of and adherence to the admission and discharge policies did not take place.

Evidence of Implementation:

Admission: The approved centre complied with Regulation 7: Clothing and Regulation 8: Personal Property and Possessions, which are associated with this code of practice. The approved centre did not comply with Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records. The clinical files of three residents were inspected against in relation to the admission process. Admission was because of a mental illness or disorder. The residents were assigned a key worker. The admission assessments were comprehensive in two cases. In the third case, the resident did not receive a physical examination at the time of admission to the approved centre. All assessments and examinations were documented in the clinical files.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The file of one resident transferred to receive specialised treatment in another facility was inspected. The registered medical practitioner made the decision to transfer the resident and the decision to transfer was agreed with the receiving facility. A resident assessment, including a risk assessment, was completed.

Discharge: The clinical files of three residents who had been discharged were reviewed. The decision to discharge the residents were made by a registered medical practitioner. A discharge plan was in place and documented as part of the residents’ individual care plans. A comprehensive discharge summary was sent within 14 days to relevant personnel as required.

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

a) The discharge policy did not reference a way of following up and managing missed appointments, 4.14.

b) One resident did not receive a physical examination at the time of admission to the approved centre, 15.3.
c) There was no documentary evidence to indicate that staff had read and understood the admission, discharge and transfer policies, 9.1.

d) The approved centre was non-compliant with a number of regulations, which were a prerequisite for compliance with this code of practice: Regulation 32: Risk Management Procedures, 7.1; Regulation 15: Individual Care Plan, 17.1; and Regulation 27: Maintenance of Records, 22.6.
## Appendix 1: Corrective and Preventative Action Plan Template - 2017 Inspection Report

### Regulation 15: Individual Care Plan

*Report reference: Page 32*

<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><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring¹ or New² area of non-compliance</strong></td>
<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>1. Two ICPs were not developed within seven days of admission.</td>
<td>New</td>
<td>Corrective Action(s): A Full baseline audit will be carried out of all current in-patient care plans and following completion of this audit, Executive Clinical Director will meet individual teams to disseminate results and implement corrective actions on care plans with identified deficits&lt;br&gt;Post-Holder(s) responsible: QPS Manager</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Preventative Action(s): Where audit results identify on-going areas of non compliance, individual information sessions will be provided to each identified team to specifically highlight and address areas for improvement in care plan&lt;br&gt;Post-Holder(s) responsible: QPS Manager/Executive Clinical Director</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
</tr>
</tbody>
</table>

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¹ Area of non-compliance reoccurring from 2016  
² Area of non-compliance new in 2017
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring 1 or New 2 area of non-compliance</strong></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>
<tr>
<td><strong>2.</strong> In five cases, ICPs reviewed were developed by nursing and medical staff only and were not developed by the MDT.</td>
<td><strong>New</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Corrective Action(s): A Full baseline audit will be carried out of all current in-patient care plans and following completion of this audit, Executive Clinical Director will meet individual teams to disseminate results and implement corrective actions on care plans with identified deficits</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td></td>
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<tr>
<td></td>
<td>Post-Holder(s) responsible: Executive Clinical Director/QPS Manager</td>
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</tr>
<tr>
<td></td>
<td>Preventative Action(s): Where audit results identify on-going areas of non compliance, individual information sessions will be provided to each identified team to specifically highlight and address areas for improvement in care plan</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: QPS Manager/Executive Clinical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> Three ICPs did not identify appropriate goals.</td>
<td><strong>New</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A Full baseline audit will be carried out of all current in-patient care plans and following completion, Executive Clinical Director will meet individual teams to disseminate results and implement corrective actions on care plans with identified deficits</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<tr>
<td>Taken from the inspection report, Reoccurring(^1) or New(^2) area of non-compliance</td>
<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 details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td></td>
<td>Where audit results identify on-going areas of non compliance, individual information sessions will be provided to each identified team to specifically highlight and address areas for improvement in care plan Post-Holder(s) responsible:</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td>4. One ICP did not identify the resources required to provide the care and treatment identified.</td>
<td>A Full baseline audit will be carried out of all current in-patient care plans and following completion, Executive Clinical Director will meet individual teams to disseminate results and implement corrective actions on care plans with identified deficits Post-Holder(s) responsible: Executive Clinical Director/QPS Manager</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Where audit results identify on-going areas of non compliance, individual information sessions will be provided to each identified team to specifically highlight and address areas for improvement in care plan Post-Holder(s) responsible:</td>
<td>Quarterly audit reports will be completed with results communicated to individual teams and operational group</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
</tbody>
</table>
### Regulation 21: Privacy

Report reference: Page 39

<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>Reoccurring or New area of non-compliance</td>
<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 details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>5. Rooms were overlooked by public areas.</td>
<td>New</td>
<td>Corrective Action(s): Works are to commence in January in relation to gardenworks. As part of this work, new screening will be attached to the exterior fencing to obscure views from public area Post-Holder(s) responsible: Business Manager</td>
<td>Quarterly safety walk of building including external areas to be carried out by site safety team which will monitor screening and its effectiveness</td>
<td>Achievable but on-going building developments in adjacent site may create future difficulties</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Quarterly safety walk of building including external areas to be carried out by site safety team which will monitor screening and its effectiveness Post-Holder(s) responsible: Site Safety team/ADON</td>
<td>Actions identified from site safety walk will be logged in maintenance log and action appropriately based on identified action with updates on progress reported through site safety team</td>
<td>Achievable</td>
</tr>
<tr>
<td>6. Residents could be identified by other residents and visitors from noticeboards.</td>
<td>New</td>
<td>Corrective Action(s): Identifiable information is no longer located on whiteboard Post-Holder(s) responsible: CNM3</td>
<td>Observational audit will be carried out through site safety walks of unit in relation to privacy</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s):</td>
<td>Observational audit will be carried out through site</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
A new system is now introduced in which essential information is accessible to staff in a discreet part of the unit office
Post-Holder(s) responsible: CNM2

| 7. | Residents were unable to ensure the privacy of their personal bedrooms from external observation. | Corrective Action(s): The default adjustable setting is to be set on the closed position. All staff will be communicated that the amended default position is set on the closed position Post-Holder(s) responsible: CNM2 | Observational audit will incorporate the examining of default positions of vision panels during the weekly maintenance check Achievable 31/01/2018 |
| Preventative Action(s): All staff to be kept informed of status of default closed setting during staff meetings and workshops in relation to privacy policy Post-Holder(s) responsible: CNM2 | Observational audit will incorporate the examining of default positions of vision panels during the weekly maintenance check Achievable 31/01/2018 |
### Regulation 22: Premises

**Report reference: Page 40-41**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.</strong> The approved centre did not have a programme of routine maintenance.</td>
<td>Reoccurring or New area of non-compliance</td>
<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 details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Corrective Action(s): A maintenance programme is established with records maintained of all works to be carried out and completed. Planned works are discussed at services operational group and site safety team. Post-Holder(s) responsible: Administration</td>
<td>Actions identified from site safety walk will be logged in maintenance log and action appropriately based on identified action with updates on progress reported through site safety team and operational group</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Update on progress of works and planned future works will be agenda item on local operational group and site safety team. Post-Holder(s) responsible: Administration</td>
<td>Actions identified from site safety walk will be logged in maintenance log and action appropriately based on identified action with updates on progress reported through site safety team and operational group</td>
<td>Achievable</td>
</tr>
<tr>
<td><strong>9.</strong> The approved centre did not have adequate and suitable furnishings for the number and mix of residents in the approved centre.</td>
<td>New</td>
<td>Corrective Action(s): Additional chairs are available within the unit which can be placed in the identified sitting rooms if required depending on demand/usage. Post-Holder(s) responsible: CNM 3</td>
<td>Views of residents will be sought at community meetings in relation to usage of sitting rooms and if any space issues arise during the day within the 2 sitting rooms</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): An audit of usage of identified sitting rooms and</td>
<td>Views of residents will be sought at community</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
| New | occupancy of rooms at given times will be carried out to monitor usage of sitting rooms and seated area  
Post-Holder(s) responsible: CNM3 | meetings in relation to usage of sitting rooms and if any space issues arise during the day within the 2 sitting rooms |  |
| --- | --- | --- | --- |
| 10. **The potential for residents to access the roof was contrary to the requirements of 22.3.** | **Corrective Action(s):**  
This door was repaired following inspection with closing mechanism adjusted  
Post-Holder(s) responsible: ADON | Actions identified from site safety walk will be logged in maintenance log and action appropriately based on identified action with updates on progress reported through site safety team and operational group | Achievable  
**Complete** |
|  | **Preventative Action(s):** A sign is located on door indicating to staff to ensure that closing mechanism is locked  
Post-Holder(s) responsible: | Actions identified from site safety walk will be logged in maintenance log and action appropriately based on identified action with updates on progress reported through site safety team and operational group | Achievable  
**Complete** |
### Regulation 23: Ordering, Prescribing, and Administration of Medicines

**Report reference: Page 42-43**

<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><strong>11.</strong> Three MPARs did not record the generic name of the medication preparation.</td>
<td>Corrective Action(s): The 3 MPARs were amended post inspection to include the generic name of the medication preparation Post-Holder(s) responsible: NCHD</td>
<td>MPAR’s examined for completion</td>
<td>Achievable</td>
<td>15/01/2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Information sessions will be provided to NCHD’s and Consultant Psychiatrists as part of the ongoing education session informing them of audit results, medication errors and JSF requirements/inspection report findings in relation to prescribing Post-Holder(s) responsible: Pharmacist/QPS Manager</td>
<td>Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised</td>
<td>Achievable</td>
<td>31st of January and week beginning 9th of July 2018</td>
</tr>
<tr>
<td><strong>12.</strong> Five MPARs did not record any medications refused by the resident, which meant the medication omission code was not recorded on the administration chart for staff to read.</td>
<td>Corrective Action(s): Workshops were held into relation to medication management practices to inform staff of medication management policy and requirements for recording omission codes Post-Holder(s) responsible: CNM3</td>
<td>Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
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<th>Specific</th>
<th>Measureable</th>
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</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<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>Achievable / Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Ongoing programme of workshops will be scheduled in relation to medication management practices to inform staff of medication management policy and requirements for recording omission codes</td>
<td>Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CNM3</td>
<td></td>
<td></td>
<td>31st of March 2018</td>
</tr>
<tr>
<td>13. A clear record of the date of discontinuation for each medication was not recorded in five prescriptions attached to MPARs.</td>
<td>Preventative Action(s): Information sessions will be provided to NCHD’s and Consultant Psychiatrists as part of the ongoing education session informing them of audit results, medication errors and JSF requirements/inspection report findings in relation to prescribing</td>
<td>Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Post-Holder(s) responsible: Pharmacist/QPS Manager</td>
<td></td>
<td>31st of January and week beginning July 9th 2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Taken from the inspection report</td>
<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 details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
</tbody>
</table>
| 14. One dose of medication was administered after its recorded stop date and was not, therefore, administered in accordance with the directions of the prescriber. | Corrective Action(s): Workshops were held into relation to medication management practices to inform staff of medication management policy and requirements for recording omission codes  
Post-Holder(s) responsible: CNM3 | Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised | Achievable              | Complete                   |
| New                                                                                        | Preventative Action(s):  
Ongoing programme of workshops will be scheduled in relation to medication management practices to inform staff of medication management policy  
Post-Holder(s) responsible: CNM3 | Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised | Achievable              | 31st March 2018             |
| 15. Withheld medication and the justification for withholding the medication was not documented in five prescriptions contained in the MPAR and the clinical file. | Corrective Action(s): Workshops were held into relation to medication management practices to inform staff of medication management policy and requirements for recording justification for withholding medication  
Post-Holder(s) responsible: CNM3 | Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised | Achievable              | Complete                   |
| New                                                                                        | Preventative Action(s):  
Ongoing programme of workshops will be scheduled in relation to medication | Quarterly audit programme of medication management utilising the medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised | Achievable              | 31st March 2018             |
<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>Reoccurring or New area of non-compliance</td>
<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 details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>management practices to inform staff of medication management policy and importance of documenting justification for withholding medication Post-Holder(s) responsible: CNM3:</td>
<td>medication checklist as part of best practice guidelines is carried out to ensure standardised audit approach is utilised</td>
<td></td>
</tr>
</tbody>
</table>
Regulation 26: Staffing

<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><strong>16. The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice. Not all health care professionals were up to date with required training in the areas of fire safety, Basic Life Support, the management of violence and aggression, 26 (4) and the Mental Health Act 2001, 26(5).</strong></td>
<td>Corrective Action(s): Additional training dates were provided to end of year following inspection in relation to BLS, PMAV, Fire Safety and Mental Health Act. 5 sessions of additional PMAV were held with 34 staff attending, dates of these training were 13/09/17, 31/10/17,15/11/2017 20/11/2017, 29/11/17, Post-Holder(s) responsible: ADON Training Co-ordinator</td>
<td>Quarterly reports will be provided to the local operational group and services clinical governance group to monitor current compliance with mandatory training</td>
<td>Currently the position of training co-ordinator within the service is now vacant due to retirement which will impact on future co-ordination of training. Current vacancies and ability to release instructors will impact on availability/frequency of training sessions and number of attendees</td>
<td>Complete</td>
</tr>
<tr>
<td>Preventative Action(s): A training schedule is currently being developed for the entire year which will incorporate BLS, PMAV, Fire safety and Mental Health Act Post-Holder(s) responsible: Nurse Practice Development Co-ordinator</td>
<td>Quarterly reports will be provided to the local operational group and services clinical governance group to monitor current compliance with mandatory training</td>
<td>Currently the position of training co-ordinator within the service is vacant due to retirement which will impact on future co-ordination of training. Current vacancies and ability to release instructors will impact on availability/frequency of training sessions and number of attendees</td>
<td>Jan 31\textsuperscript{st} 2018</td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
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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>
</tr>
<tr>
<td>17. Not all records were maintained in good order - six files contained loose pages.</td>
<td>Corrective Action(s): Where large files existed, an extra volume was created to prevent loose pages and aid accessibility</td>
<td>Ongoing audit programme in relation to maintenance of records will monitor and assess on order and filing of notes</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CNM2</td>
<td></td>
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<tr>
<td></td>
<td>Preventative Action(s): Weekly check of volume of notes will take place to ensure file size does not become unmanageable</td>
<td>Ongoing audit programme in relation to maintenance of records will monitor and assess on order and filing of notes</td>
<td>Achievable</td>
<td>31st January 2018</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CNM2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. All records and reports were not kept in a safe secure place.</td>
<td>Corrective Action(s): All records and reports were removed from the observational desk with additional storage provided through extra filing cabinets</td>
<td>Observational audit during walk through of unit</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CNM2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): A sub group is now developed to seek alternative options and designs and practices in relation to the observational area located in the Psychiatry of Old Age Area (POA)</td>
<td>Update on progress and findings of group will be reported to local operational group</td>
<td>Limited alternative areas available on POA unit to re-locate observational area.</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CNM3/Occupational Therapist/CNM2</td>
<td></td>
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</tbody>
</table>
Regulation 28: Register of Residents

Report reference: Page 50

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
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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>
</tr>
<tr>
<td>19. The register of residents did not contain all of the information required under Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Residents’ address, next of kin/representatives, diagnosis date, and diagnosis on discharge were not detailed on the register.</td>
<td>Corrective Action(s): The specific details for provisional diagnosis on admission and discharge diagnosis have being included on the assessment proforma Post-Holder(s) responsible: NCHD’s</td>
<td>A monthly report will be provided on the compliance levels of recording provisional diagnosis and discharge diagnosis</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td>Preventative Action(s): As part of the induction and information sessions for medical practitioners, reports of monthly audits will be disseminated and communicated Post-Holder(s) responsible: Medical Records Administrator</td>
<td>A monthly report will be provided on the compliance levels of recording provisional diagnosis and discharge diagnosis</td>
<td>Achievable</td>
<td>1st February</td>
<td></td>
</tr>
</tbody>
</table>
## Regulation 29: Operating Policies and Procedures

**Report reference: Page 51**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
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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></td>
</tr>
<tr>
<td>20. The policy for Regulation 27: Maintenance of Records had not been reviewed within the stipulated three-year period and was, therefore, out of date.</td>
<td>Corrective Action(s): A sub group is formed consisting of representatives from DDOP to review the current maintenance of records Policy&lt;br&gt;Post-Holder(s) responsible: QPS Manager</td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Achievable</td>
<td>31st March 2018</td>
</tr>
<tr>
<td>New</td>
<td>Preventative Action(s): A database will be maintained of all the approved policies with implementation date and review dates which will be reviewed on a quarterly basis&lt;br&gt;Post-Holder(s) responsible: CNM3</td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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</tr>
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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>
</tr>
<tr>
<td>21. The approved centre did not have an emergency evacuation plan in place.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>Corrective Action(s): A sub group was formed and have now developed a major emergency plan for the DDOP</td>
<td>The major emergency plan will be reviewed at a minimum on a yearly basis by the Site Safety Team within the DDOP</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: QPS Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Action(s): A database will be maintained of all the approved centre policies with implementation date and review dates which will be reviewed on a quarterly basis</td>
<td></td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Achievable</td>
<td>31st of March 2018</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: CNM3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section 69: The Use of Seclusion

**Report reference: Page 61**

<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>Reoccurring or New area of non-compliance</td>
<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>
</tbody>
</table>
| **22.** One episode of seclusion was not fully documented in the seclusion register. | **New** | Corrective Action(s): Workshops provided to staff on the recording requirements in relation to the use of seclusion  
Post-Holder(s) responsible: CNM3 | Regular audit programme on the recording requirements of seclusion will be carried out with report provided to operational group | Achievable | Complete |

**Preventative Action(s):**  
Ongoing programme of workshops will be scheduled in relation to seclusion management policy and requirements as set out in Rules  
Post-Holder(s) responsible: CNM3:  
Seclusion checklist in best practice guidelines will be used following each episode of seclusion to monitor recording requirements  
Post-Holder(s) responsible: CNM2  
Regular audit programme on the recording requirements of seclusion will be carried out with report provided to operational group  
Achievable | 31<sup>st</sup> March 2018 |

<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>
</table>
| Taken from the inspection report | Reoccurring | Corrective Action(s): Workshops on specific policies including the Seclusion Policy will be provided to staff and following workshop, a record will be maintained of attendance and who facilitated sessions  
Post-Holder(s) responsible: ADON/CNM3 | An annual audit on number of signatures on service polices including seclusion will be carried out | Achievable | 31/03/2018 |

**Preventative Action(s):**  
A self assessment process is established as part of the implementation of HSE Best Practice Guidelines for Mental Health Services which will ask staff on their awareness and knowledge of policies  
Post-Holder(s) responsible: Self Assessment Team Lead/ADON  
The Self assessment team will interview staff and record compliance on the Guidance Assessment Improvement Tool  
Achievable | 30/06/2018 |
### Part 4: Consent to Treatment

**Report reference: Page 64-65**

<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>Reoccurring or New area of non-compliance</td>
<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 details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>24. The written record of consent in the clinical file did not contain confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s). In addition, it did not contain any record of supports provided to the patient in relation to the discussion and their decision-making.</td>
<td>Corrective Action(s): Clinical file was updated to incorporate requirements  Post-Holder(s) responsible: Consultant Psychiatrist</td>
<td>File checked to ensure recording requirements complete</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): A alert system is now in place by the Mental Health Act Administrator which informs Consultant Psychiatrists in advance of 3 month requirement and includes proforma and outlines recording requirements  Post-Holder(s) responsible: Mental Health Act Administrator</td>
<td>A 6 monthly audit will be carried to examine compliance with recording requirements</td>
<td>Achievable</td>
<td>Complete and ongoing</td>
</tr>
</tbody>
</table>
### Code of Practice: Admission of Children

**Report reference: Page 68**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Reoccuring or New area 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></td>
<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 details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>25. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child residents.</td>
<td>New</td>
<td>Corrective Action(s): At all times, the admission of children will only be considered when no other alternative or safe option is available</td>
<td>Monthly reports will be provided in relation to the admission of children to the area management team</td>
<td>Difficulties with access to in-patient beds nationally has led to approved centre having to admit child when no CAMHS in-patient bed available</td>
<td>February 1st 2018</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Preventative Action(s):; In the event where it is necessitated to admit a child, the decision to admit will be discussed with the Executive Clinical Director with a discharge plan in place to minimise the length of admission</td>
<td>Monthly reports will be provided in relation to the admission of children to the area management team</td>
<td>Difficulties with access to in-patient beds nationally has led to approved centre having to admit child when no CAMHS in-patient bed available</td>
<td>February 1st 2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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</tr>
<tr>
<td>26. There was no policy in relation to the training of staff in working with people with an intellectual disability.</td>
<td>Corrective Action(s): A sub group was formed to review current policy and incorporated into revised policy on Care and Treatment of persons with an intellectual disability and mental health needs a specific section on training requirements Post-Holder(s) responsible: QPS Manager</td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Achievable</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): A database will be maintained of all the approved centre policies with implementation date and review dates which will be reviewed on a quarterly basis Post-Holder(s) responsible: CNM3</td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Achievable</td>
<td>31st of March 2018</td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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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>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>27. The discharge policy did not reference a way of following up and managing missed appointments.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): A sub group was formed to review the current discharge policy Post-Holder(s) responsible: QPS Manager</td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Difficulties with implementation as approved centre does not govern the allocation of appointments or follow up of missed appointments. This is carried out by the respective community teams where the out patient appointments are scheduled</td>
<td>March 31st 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): A audit of the policy will be completed on a yearly basis to ensure policy meets requirements of Code of Practice Post-Holder(s) responsible: CNM3</td>
<td>A yearly audit will be carried out in the DDOP to review the timelines of expiry dates of policies to ensure adequate notice is provided to commence work on updating policy before expiry date</td>
<td>Achievable</td>
<td>June 30th 2018</td>
</tr>
<tr>
<td>28. One resident did not receive a physical examination at the time of admission to the approved centre.</td>
<td>New</td>
<td>Corrective Action(s): The physical examination was completed post inspection Post-Holder(s) responsible: NCHD</td>
<td>File was examined for completion</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): As part of the ongoing NCHD induction, the admission policy and its requirements with regard to</td>
<td>An annual audit will be completed as part of the admission process which as part of its criteria will</td>
<td>Achievable</td>
<td>31st of January 2018 and 9th of July 2018</td>
</tr>
</tbody>
</table>
| Reoccurring | physical examinations will be incorporated into the induction process  
Post-Holder(s) responsible: NCHD Tutors | assess the completion of physical examinations during admission. The results of the audit will be disseminated to NCHD’s and consultants |
|---|---|---|
| 29. There was no documentary evidence to indicate that staff had read and understood the admission, discharge and transfer policies. | Corrective Action(s): Workshops on specific policies including admission, transfer and discharge will be provided to staff and following workshop, a record will be maintained of attendance and who facilitated sessions  
Post-Holder(s) responsible: ADON/CNM3 | An annual audit on number of signatures on service polices including seclusion will be carried out  
Achievable  
31/03/2018 |
| Preventative Action(s): A self assessment process is established as part of the implementation of HSE Best Practice Guidelines for Mental Health Services which will ask staff on their awareness and knowledge of policies  
Post-Holder(s) responsible: Self Assessment Team Lead/ADON | The Self assessment team will interview staff and record compliance on the Guidance Assessment Improvement Tool  
Achievable  
30/06/2018 |