St. Anne's Unit, Sacred Heart Hospital

ID Number: AC0072

2017 Approved Centre Inspection Report (Mental Health Act 2001)

St. Anne's Unit, Sacred Heart Hospital
Castlebar
Co. Mayo

Approved Centre Type: Psychiatry of Later Life

Most Recent Registration Date: 1 October 2014

Conditions Attached: None

Registered Proprietor: HSE

Registered Proprietor Nominee:
Steve Jackson, General Manager, CHO2 – Mental Health Services

Inspection Team:
Dr David McGuinness, Lead Inspector
Donal O’Gorman
Leon Donovan

Inspection Date: 30 May – 2 June 2017

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 25 – 28 October 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: 9 November 2017

2017 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

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

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

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

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

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

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

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

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

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

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

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

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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

The approved centre had a written policy in relation to health and safety and a site-specific safety statement. The risk management policy did not reference arrangements for the protection of children and vulnerable adults from abuse. The current risks in the approved centre were not being logged in a local risk register.

Name and date of birth of residents were checked before the administration of medication, medical investigations, and the provision of other health care services. Food safety audits had been completed. Hygiene was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned. As the approved centre were now admitting residents with mood disturbance, with possible associated higher risk of suicide, ligature points posed an increased risk. Medication was ordered, prescribed, stored and administered in a safe manner. Not all staff had received training in fire safety, Basic Life Support, management of aggression and violence 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

For residents with special dietary requirements, the St. Andrew’s Nutrition Screening Instrument (SANSI) nutrition assessment tool was in use in the approved centre. The needs of residents identified as having special nutritional requirements were reviewed every month by the dietician. While each resident had an individual care plan, not all were completed in line with the relevant regulation. The range of available, evidence-based programmes was appropriate to the assessed needs of residents, as outlined in their individual care plans. Therapeutic services and programmes were tailored towards dementia patients. Residents’ physical health was assessed on admission and on an ongoing basis. Residents received appropriate general health care as indicated in their individual care plans, and their general health needs were monitored and assessed at least every six months. Staff were trained in accordance with the assessed needs of residents, with training delivered in manual handling and dementia care. Clinical files were kept in good order. Seclusion and Mechanical restraint were not used in the approved centre and no resident had
been physically restrained. Care and treatment of a resident with an intellectual disability was in accordance with the relevant code of practice.

**Respect for residents’ privacy and dignity**

Privacy was respected in the approved centre and staff were observed to treat residents with respect. Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs. Residents could bring personal possessions into the approved centre and were supported to manage their own property. When the approved centre assumed responsibility for residents’ personal property and possessions, it provided suitable facilities for the safe-keeping of these items.

**Responsiveness to residents’ needs**

Food, including modified consistency diets, was presented in an appealing manner. Residents were provided with a range of wholesome and nutritious food choices, and hot meals were served on a daily basis. Residents had access to appropriate recreational activities, which were scheduled in the approved centre on weekdays and at weekends. Recreational activities were appropriately resourced and delivered by an activation nurse and an occupational therapist. Opportunities were available for indoor and outdoor exercise and physical activity. Residents were facilitated in the practice of their religion and there was a chapel on-site. Visiting times were appropriate, reasonable, and flexible. There was a designated area where residents could meet with visitors in private. Children were welcome and the visiting room was suitable for visiting children. Residents had access to external communications, including telephone, mail, and Internet. Appropriate information about the approved centre, housekeeping arrangements, diagnosis and medication was provided for the residents. The approved centre was in a good state of repair and was clean. There was adequate communal space. There was a robust complaints procedure in place that was well advertised.

**Governance of the approved centre**

The Mayo Mental Health Service was part of Community Healthcare Organisation (CHO) 2, and there were plans to establish an overarching area management team for the entire CHO 2 area. There was an organisational chart and clear governance structures and processes in place. Minutes of the Mayo Mental Health Services area management team meetings evidenced regular senior management meetings and governance structures, which addressed issues such as the risk register, strategic plan, policies, and quality

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**AREAS REFERRED TO**

and patient safety. There were two Psychiatry of Later Life teams, the North and the South Team. Both had responsibility for the care and treatment of residents in St. Anne’s unit. The Psychiatry of Later Life team held a monthly business meeting and all disciplines were represented at this forum. This team had developed a service development plan. Operating policies and procedures were developed with input from clinical and managerial staff in consultation with all relevant stakeholders. Policies and procedures were electronically communicated to all relevant staff.

**AREAS REFERRED TO**

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

1. The St. Andrew’s Nutritional Screening Instrument was implemented in order to help with the systematic assessment of residents’ nutrition needs.
2. A new weekly music group was being delivered as a recreational activity for service users.
3. Two new flat-screen televisions were installed for service users.
4. An electronic tablet and WiFi were available to service users.
5. A *Judgment Support Framework* working group was in place, which supported the approved centre in adhering to standards.
6. Work e-mail accounts had been activated for all staff, including registered psychiatric nurses, multi-task attendants, and health care assistants.
7. A new policy portal was introduced to help with the dissemination of policies among all staff.
8. An active policy, protocol, and guidelines committee was in place and policies were circulated on a shared drive with electronic staff signatures.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was a Psychiatry of Later Life unit located on the grounds of the Sacred Heart Hospital on the Pontoon Road, Castlebar, Co. Mayo. The approved centre was a locked, ground-level, single-storey building dating to the 1970s. This unit provided interim care and limited respite care for people over the age of 65 years. There were three single bedrooms and four dormitory-style bedrooms.

There were 12 beds, which primarily accommodated people experiencing dementia, as well as people who had other mental health needs. As there had been a change in the resident profile from mainly residents with dementia to include higher risk residents, the elimination/minimisation of potential ligature points had become more urgent. A design team had developed a plan for the premises and this was to be referred to the general manager.

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>12</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>11</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>1</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>2</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

There was an organisational chart and clear governance structures and processes in place. Minutes of the Mayo Mental Health Services area management team meetings were provided to the inspection team. These minutes evidenced regular senior management meetings and governance structures, which addressed issues such as the risk register, strategic plan, policies, and quality and patient safety. The Mayo Mental Health Service was part of Community Healthcare Organisation (CHO) 2, and there were plans to establish an overarching area management team for the entire CHO 2 area.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 25 - 28 October 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>

5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</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 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 7: Clothing</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 inspection team met with two residents during the course of the inspection. Residents were complimentary of the care and treatment that was provided to them by nursing, medical, psychology, and occupational therapy staff. Residents commented positively on the food and the friends that they had made among other service users.
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:

- The Area Director of Nursing
- The Principal Psychologist
- The consultant psychiatrist with responsibility for the approved centre
- The Acting Occupational Therapy Manager
- The Principal Social Worker
- The Business Manager

There were two Psychiatry of Later Life teams, the North and the South Team. One of the consultant psychiatrists was a locum. Both had responsibility for the care and treatment of residents in St. Anne’s unit. While the South Team had a complement of MDT members, the North Team did not. A social worker had recently been appointed, but there was no occupational therapist or psychologist for the North Team. The medical, nursing, and occupational therapy heads of discipline had responsibility for mental health services alone. The head of discipline for social work and psychology had responsibility for a wider range of services, including social care, disability, primary care, and Tusla services.

The direct line manager was a senior grade professional and each staff member was provided with clinical and professional supervision. There were clear processes for escalating issues of concern to heads of discipline and to the area management team. There were defined line management structures and processes in place for all disciplines. All heads of discipline had training in National Incident Management System, while one head of discipline did not have training in health and safety. Each head of discipline held regular meetings, approximately monthly, with senior staff. There were regular discipline-wide meetings scheduled also.

The Assistant Director of Nursing visited the approved centre weekly and liaised with the area director of nursing. The business manager visited approximately three to four times per year and maintained the audits for the approved centre as well as being responsible for securing funding for furniture and equipment.

The health and social care professionals reported that the line manager supervision process would incorporate elements of performance management.

The area lead of mental health engagement was a member of the area management team. The Psychiatry of Later Life team held a monthly business meeting and all disciplines were represented at this forum. This team had developed a service development plan.
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:

- Head of Service Mental Health
- Consultant Psychiatrist x 2
- Area Lead Mental Health Engagement
- Nursing Practice Development Coordinator
- Principal Social Worker
- Specialist Registrar
- Clinical Nurse Manager 2 x 2
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Acting Occupational Therapy Manager
- Quality and Risk Manager
- Business Manager

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

The specialist registrar stated that a training workshop on individual care plans had been facilitated by a non-consultant hospital doctor. The nurse practice development coordinator stated that she would e-mail a more up-to-date policy on care and treatment of persons with an intellectual disability in mental health services to the inspection team.
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 written policy in relation to the identification of residents, which was last reviewed in October 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: All relevant staff had signed a signature log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that appropriate resident identifiers were used on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: At least two person-specific resident identifiers were used in the approved centre and were specified within the residents’ clinical files. Name and date of birth were checked before the administration of medication, the initiation of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

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 5: Food and Nutrition

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was dated August 2016. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: A systematic review of menu plans had not taken place to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: At the time of the inspection, food was delivered to the approved centre from Mayo General Hospital. Menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Food, including modified consistency diets, was presented in an appealing manner. Residents were provided with a range of wholesome and nutritious food choices, and hot meals were served on a daily basis. Residents had regular access to hot and cold drinks and to a supply of safe, fresh drinking water.

For residents with special dietary requirements, the St. Andrew’s Nutrition Screening Instrument (SANSI) nutrition assessment tool was in use in the approved centre. The needs of residents identified as having special nutritional requirements were reviewed every month by the dietitian. Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans.

Weight charts were implemented, monitored weekly, and acted upon, where required. Residents, their representatives, family, and next of kin were educated about residents’ diets by the dietitian, where appropriate.

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 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 written policy in relation to food safety, which was last reviewed in October 2016. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: Food safety audits had been completed. Food temperatures were in line with food safety recommendations, and a temperature log sheet was maintained and monitored. Analysis had been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services, and there was suitable catering equipment, with appropriate facilities for the refrigeration, storage, and serving of food. Hygiene was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

The approved centre had very limited catering facilities. It served food transported in hot boxes from Mayo General Hospital. It did not have the facilities to prepare or cook meals on-site.

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 evidence of implementation pillars.
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy on clothing. Relevant staff interviewed could articulate the processes in relation to residents’ clothing, as set out in the policy.

Monitoring: The approved centre had a large supply of emergency male and female clothing, which was monitored by the clinical nurse manager. A record of residents being nursed in nightclothes during the day was maintained. At the time of the inspection, no resident was wearing nightclothes during the day.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs. Residents were helped with their personal laundry by staff. Residents’ personal clothing was appropriately labelled.

An emergency supply of clothing was available in the residents’ property room. Staff also had access to a cash fund in the event that a resident required personal clothing. Emergency clothing took account of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans. All residents had an adequate supply of individualised clothing and a wardrobe in which to store their clothes.

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 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in May 2016. It included requirements of the Judgement Support Framework, with the exception of processes for the following:

- Communicating with residents and their representatives regarding residents’ entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.
- Allowing residents to have access to or control over their personal property, unless this posed a danger to themselves or others, as indicated in their individual care plans (ICPs), following a risk assessment.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to residents’ property and possessions, as set out in the policy.

Monitoring: Each resident had a personal property log, which was maintained and monitored. No analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions. An audit of resident monies had been undertaken to ensure that staff were adhering to the policy and that the procedures for handling and securing resident monies were appropriate.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their ICPs. When the approved centre assumed responsibility for residents’ personal property and possessions, it provided suitable facilities for the safe-keeping of same.
The approved centre maintained a signed property checklist detailing each resident’s personal property and possessions. A copy of the checklist was given to the resident, and a duplicate copy was retained by staff in the property book. The checklist was kept separately to the resident’s ICP.

Two members of staff oversaw the process of providing residents with access to their monies, and signed records of staff issuing the money were retained. Where possible, the record was countersigned by the resident or their representative.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
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 in relation to the provision of recreational activities, which was dated June 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake/attendance. Analysis had not been completed to identify opportunities for improving the processes for recreational activities.

Evidence of Implementation: Residents had access to appropriate recreational activities. These included hair and beauty treatments, walks, an exercise bike, newspapers, books, television, music, and gardening.

Recreational activities were scheduled in the approved centre on weekdays and at weekends. A list of activities was on display, but it contained no information about the types and frequency of appropriate recreational activities available. Activities were developed, maintained, and implemented with resident involvement. Individual risk assessments were completed for residents, where appropriate, in relation to the selection of activities.

Recreational activities were appropriately resourced and delivered by an activation nurse and an occupational therapist. Opportunities were available for indoor and outdoor exercise and physical activity. Outdoor facilities included a large outdoor courtyard with planters and raised flower beds; indoor facilities included a large communal room, with books, TV, puzzles, and music.

Residents’ decisions on whether or not to participate in activities were respected and recorded in their clinical files. Records of resident attendance at events were maintained in the clinical files.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of a provision for respecting a resident’s religious beliefs and values within the routines of daily living, including resident choice regarding their involvement in religious practice.

Training and Education: All relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: There was no documented evidence that a review of the policy’s implementation had been completed to ensure that residents’ identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. There was a large chapel on-site, and residents were supported to attend mass or to listen to mass on television. A priest visited weekly, and Eucharistic ministers visited twice weekly. Residents also had access to multi-faith chaplains, where required. Following a risk assessment, residents were supported to access religious services outside of the approved centre, if deemed appropriate.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Restrictions on residents’ rights to receive visitors were monitored, reviewed, and audited. Analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate, reasonable, and flexible, were publicly displayed in the approved centre. There was a designated area where residents could meet with visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Children were welcome and had to be accompanied at all times by an adult to ensure their safety. The visiting room was suitable for visiting children.

At the time of the inspection, there were no visitor restrictions in place.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in May 2017. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating residents’ communication needs.

Monitoring: Residents’ communications needs and restrictions on communication were assessed at admission and monitored on an ongoing basis by clinical staff. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to external communications, including telephone, mail, and Internet. Where appropriate, individual risk assessments were completed for residents in relation to risks associated with their external communication and documented in their individual care plans. At the time of the inspection, no resident had been identified as having a communication risk. At the time of the inspection, no resident communication was subject to examination for safety reasons.

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 a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to searches. Entitled *Policy on Searching Service Users, With and Without Consent*, which was last reviewed in August 2014. It addressed requirements of the *Judgement Support Framework*, including the following:

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

The policy did not reference the application of individual risk assessments in relation to resident searches or the processes for communicating the search policy and procedures to residents and staff.

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for undertaking a search, as set out in the policy.

As no searches had been carried out in the approved centre since the 2016 inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

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

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: All relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policy.

Since the last inspection, no resident had received end of life care and there had been no sudden or unexplained deaths in the approved centre. As a result, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in August 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes relating to individual care planning. Multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: ICPs were audited on a quarterly basis to assess compliance with the regulation. Analysis had been completed to identify opportunities for improving the individual care planning process and an action plan was put in place.

Evidence of Implementation: The clinical files of 11 residents were inspected. In each case, the ICP was a composite set of documents stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes.

In each of the files inspected, residents received a comprehensive assessment at admission and an initial care plan was drawn up. Evidence-based assessments were used where possible. In all of the files examined, a key worker was identified to ensure continuity in the implementation of an ICP and ICPs were reviewed monthly.

In four cases, the ICP was not developed within seven days of admission. The MDT met once a month, and full ICPs were not put in place until after the first MDT meeting following an admission. Two ICPs did not record family or resident involvement in care planning, with no explanation as to why. Four ICPs had not been signed by the residents and there was no evidence that the residents had received copies of their plans. One ICP did not specify the resident’s needs or goals or the interventions required. Three ICPs did not include a discharge plan.

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

a) In four cases, the full ICP was not developed by the MDT following admission until after the first MDT meeting (held monthly); therefore ICP’s were not regularly reviewed and updated.
b) One ICP did not specify the resident’s goals.

c) One ICP did not specify details of the interventions that were in place for residents.

d) Two ICP’s developed by the MDT failed to document any evidence that the preparation and review of the ICP had been undertaken (as far as reasonably practicable) in consultation with the resident, including involvement of family where appropriate. In addition, it was no recorded that the resident was offered a copy of their ICP and rationale for not doing so was not recorded.
(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 the provision of therapeutic services and programmes to residents, which was dated October 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had not been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The range of available, evidence-based programmes was appropriate to the assessed needs of residents, as outlined in their individual care plans. Therapeutic services and programmes were tailored towards dementia patients and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. There was significant crossover between therapeutic services and programmes and recreational activities because of the resident profile.

A list of therapeutic services and programmes provided in the approved centre was available. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be delivered by an approved, qualified health professional in an appropriate location. Therapeutic services and programmes were delivered in the activation room and communal room, where there were facilities and space for individual and group therapies. Residents’ participation and engagement in therapeutic services and programmes and the outcomes achieved were documented.

Adequate and appropriate resources were available to provide therapeutic services and programmes in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
Regulation 17: Children’s Education

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

### INSPECTION FINDINGS

As the approved centre did not admit children, this regulation was not applicable.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the transfer of residents, which was last reviewed in September 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

Monitoring: The approved centre maintained a transfer log, and each transfer record was systematically reviewed to ensure that all relevant information was provided to the receiving facility. Analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical files of two residents were inspected in relation to transfers. Both residents were transferred to another facility for medical reasons. The decision to transfer was made by the registered medical practitioner and agreed with the receiving facility. The decision to transfer was documented and justified, and there was clear documentation in relation to both transfers. The consent of the residents to transfer was documented in both clinical files.

Prior to the transfer, an assessment of the residents was undertaken, including a risk assessment. Full and complete written information regarding the residents was transferred to the receiving facility. In the case of an emergency transfer, communication between the approved centre and the receiving facility were documented and followed up with a written referral. Copies of all records relevant to the resident transfer process were retained in the clinical files. The clinical files were transferred with the residents, along with the medical record and a summary report, and copies of all documentation relevant to the transfer were retained in the clinical files. Appropriate referral letters were issued and included a list of current medications and details of the required medication for the resident during the transfer.

In one case, a transfer form was not completed and a checklist was not used to ensure that 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 and evidence of implementation pillars.
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had two policies in relation to the provision of general health care to residents: a general health policy, dated April 2017, and a medical emergencies policy, dated June 2017. Together, the policies included all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ take-up of national screening programmes was recorded in their clinical files and monitored. A systematic review of clinical files was regularly undertaken to ensure that six-monthly general health assessments of residents took place, and a general health matrix was used to track health care reviews. Analysis had been completed to identify opportunities for improving general health processes; an audit on physical health reviews had been completed in April 2017.

Evidence of Implementation: The approved centre had a resuscitation trolley and an Automated External Defibrillator, both of which were checked weekly. There had been no medical emergencies in the approved centre since the 2016 inspection.

A non-consultant hospital doctor assessed residents’ physical health on admission and on an ongoing basis. Residents received appropriate general health care as indicated in their individual care plans, and their general health needs were monitored and assessed at least every six months.

Residents could access general health services or be referred to other health services, as required. Records were maintained of residents’ completed general health checks and the associated results. Residents also had access to national screening programmes, and information was available on the national screening programmes that were available through the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 20: Provision of Information to Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to the provision of information to residents, which was last reviewed in August 2016. It included requirements of the Judgement Support Framework, with the following exceptions:

- The requirements relating to information provided to residents on an ongoing basis.
- The process for identifying residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.
- The process for managing the provision of information to resident representatives, family, and next of kin.

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

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Analysis had not been completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was given to residents and/or their representatives at admission in the form of a resident information booklet. Details were provided of the available care and services as well as of housekeeping arrangements, complaints procedures, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents’ rights.

Residents were provided with information on their multi-disciplinary team. They received written and verbal information regarding their diagnosis, unless, in the view of the treating psychiatrist, the provision
of such information might be prejudicial to their physical or mental health. The capacity of residents to understand the information given was noted in the clinical files.

A variety of diagnosis- and medication-related information was readily available. A medication information folder was available to residents and their families. It included information on the effects of treatment and potential side-effects of medication. Where required, staff provided residents and their families with copies of information sheets on medications and diagnoses. The medication folder also contained relevant information on such topics as advocacy, support for carers, statutory and voluntary agencies, changed behaviours, dementia care, and care for residents with dementia.

Medication sheets included information on the medications that were mainly used by the multi-disciplinary team for the treatment of cognitive decline and dementia. The information provided was derived from approved sources and learning portals. Information documents provided by or in the approved centre were appropriately reviewed before they were introduced. Where necessary, residents had access to interpretation and translation services.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was dated June 2016. It included requirements of the Judgement Support Framework, with the exception of the following:

- The method for identifying residents’ privacy and dignity expectations and preferences.
- The approved centre’s layout and furnishing requirements to support resident privacy and dignity.
- The process applied where resident privacy and dignity were not respected by staff.

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

Monitoring: There was no evidence that an annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were referred to by their preferred names, and staff members were observed to address residents in a polite and helpful manner at all times. Staff were seen to interact with residents with dignity and respect. Staff were appropriately attired, sought permission before entering residents’ bedrooms, and conducted all conversations relating to clinical and therapeutic needs in private. Residents wore clothing that respected their privacy and dignity.

The approved centre’s layout and furnishings were conducive to resident privacy and dignity. Bathrooms, showers, toilets, and single rooms had locks on the inside of the doors, and these had an override facility. Where residents shared a room, adequate privacy curtains were in place around the beds.

Windows and observation panels were appropriately screened. Noticeboards did not display identifiable resident information. Residents were facilitated in making and taking private phone calls.

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 monitoring pillars.
Regulation 22: Premises

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

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

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

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

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

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and

INSPECTION FINDINGS

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

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

Monitoring: The approved centre had completed hygiene and ligature audits. Premises was identified as a risk and was placed on the risk register.

Evidence of Implementation: The approved centre’s physical environment provided an opportunity for residents to maintain and improve their mental and general health, with adequate indoor and outdoor spaces available. Residents had access to personal space, including suitable accommodation, and to shared space in the form of bright and spacious communal rooms. There was an enclosed outdoor courtyard where residents could tend plants.

Communal areas were adequately lit to facilitate reading and other activities. Rooms were bright, ventilated, and they were suitably sized and furnished to suit the residents’ needs. Appropriate signage was in place to support resident orientation needs. Hazards were minimised, but numerous ligature points had not been addressed.
As the approved centre were now admitting residents with mood disturbance with possible associated higher risk of suicide which it did not in the past, the approved centre ligature point posed an increased risk.

The approved centre was in a good state of repair, inside and out. There was a programme of general maintenance, which was documented. There was an appropriate maintenance reporting system. A daily cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours. National infection control guidelines were followed.

Rooms were centrally heated, however the heating could not be controlled in residents’ individual rooms.

There were adequate toilet and bathroom facilities, including assisted needs facilities. There were designated sluice, cleaning, and laundry rooms, but no dedicated examination room. Medical examinations were completed in residents’ bedrooms or behind curtains in shared rooms.

Single rooms were appropriately sized, and shared rooms were large, accommodating a maximum of three residents each. Furnishings throughout the approved centre supported residents’ independence and comfort. Assisted devices and/or equipment were available, where required.

The approved centre was not compliant with this regulation because ligature points had not been minimised, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

COMPLIANT
Quality Rating Satisfactory

(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 policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in September 2016. It included requirements of the Judgement Support Framework, with the exception of the processes for medication management at admission, transfer, and discharge.

Training and Education: All nursing and medical staff as well as pharmacy staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Nursing, medical, and pharmacy staff had access to up-to-date information on all aspects of medication management, and all clinical staff had completed the HSE Land Medication Management Module.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication errors. Analysis had been completed to identify opportunities for improving medication management, and action plans were developed.

Evidence of Implementation: An MPAR was maintained for each resident, and all 11 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full. The frequency of administration, the dosage, and the administration route for medications were recorded.

The generic name of a medication was not recorded in one MPAR, and the allergy section had not been completed in two MPARs.

Residents’ medication was reviewed at least six-monthly and MPARs were rewritten where necessary. Where there were alterations in the medication order, the medical practitioner rewrote the prescription. All medicines were administered by a registered nurse or register medicinal practitioner. Medication was appropriately administered. Good hand-hygiene and cross-infection control measures were implemented during the dispensing of medications. Nursing staff checked the expiration date of the medication prior to administration.
Where a resident’s medication was withheld, the justification was noted in the MPAR and documented in the respective clinical file. Where a resident refused medication, this was documented in the MPAR and clinical file and communicated to medical staff.

Controlled drugs were checked by two staff members against the delivery form and recorded in a controlled drug book. The controlled drug balance corresponded with the balance recorded in the book. Directions to crush medication were only accepted from residents’ medical practitioner. At the time of the inspection, no resident was in receipt of crushed medication.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a daily log of medication fridge temperatures was maintained. Medication storage areas were free from damp and mould and were clean and well maintained. No food or drinks were kept in areas used for storing medication.

The medication trolley was locked and secured in a locked clinical room, and scheduled controlled drugs were secured separately. Medication dispensed to residents was stored securely in a locked trolley in the locked clinical room. A system of stock rotation was in place, and an inventory of medications was completed monthly.

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 evidence of implementation pillars.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, dated May 2016, and a site-specific safety statement, dated June 2016. The policy and safety statement addressed requirements of the Judgement Support Framework, with the exception of vehicle controls.

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

As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to staffing, which was last reviewed in March 2016. It addressed requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment of staff.
- The approved centre’s recruitment, selection, and appointment process, including Garda vetting requirements.

The policy did not include a process for transferring responsibility between staff members.

Training and Education: All relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

Monitoring: There was documented evidence that the implementation and effectiveness of the staff training plan had been reviewed on an annual basis. The number and skill mix of staff had been assessed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rota were in place. Staff were recruited, selected, and vetted by the HR department on St. Mary’s campus in line with National Recruitment Service guidelines. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times.

The recruitment of staff was a challenge for some heads of disciplines. There was no occupational therapist or psychologist covering one of the Psychiatry of Later Life teams.
The approved centre had a written staffing plan, and annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed by staff.

Not all health care professionals had up-to-date training in fire safety, Basic Life Support (BLS), Professional Management of Aggression and Violence (PMAV), and the Mental Health Act (MHA) 2001.

Of the 13 nursing staff, 10 had crisis prevention training, 12 had BLS training, 8 had fire safety training, and all had training in the MHA 2001. The two social workers were trained in the MHA 2001, neither had up-to-date BLS training, and one had training in crisis prevention and fire safety. Of the six medical staff, three had crisis prevention training, three had BLS training, and none had fire safety training or training in the MHA 2001. The occupational therapist was up to date with all mandatory training, and the psychologist had been trained in crisis management, fire safety, and the MHA 2001 but not in BLS.

At least one staff member was trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training delivered in manual handling, dementia care, care for residents with an intellectual disability, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and protection of children and vulnerable adults.

Staff training was documented, and staff training logs were maintained. Resources were available to staff for further training and education, and training was delivered by appropriately qualified individuals. The MHA 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in 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>St. Anne’s Unit</td>
<td>CNM3</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activation Nurse</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

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

The approved centre was not compliant with this regulation because not all staff had up-to-date mandatory training in fire safety, BLS, PMAV, and the MHA 2001, 26(4).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in March 2017. It covered requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

The policy did not reference record review requirements or the process for making a retrospective entry in residents’ records.

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

Monitoring: Resident records had been audited in May 2017 to ensure their completeness, accuracy, and ease of retrieval. Analysis had been conducted to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were observed to be securely stored, up to date, and in good order. They were developed and maintained in a logical sequence, and they were maintained appropriately, with factual, complete, and accurate entries that facilitated information retrieval. Residents’ records were stored together in the nurses’ station.
Each resident had an individual clinical file, and residents’ records were reflective of their current status and the care and treatment being provided. Appropriate identifiers were in use. Resident records were accessible to and could be written up by authorised staff only.

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

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

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date and contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in April 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff had received training 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 was undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the process of developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff in consultation with all relevant stakeholders. Policies and procedures, which incorporated relevant legislation, evidence-based best practice, and clinical guidelines, were electronically communicated to all relevant staff. Operating policies and procedures were appropriately approved by the area management team before becoming effective.

All operating policies and procedures required by the regulations were reviewed within the required three-year time frame, and obsolete versions were removed from circulation. Operating policies and procedures were presented in a standardised format that included title, reference and version number, details of the document owner, date of implementation, and details of approvers and reviewers.

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 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

As there had been no Mental Health Tribunals in the approved centre since the last inspection, this regulation was not applicable.
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 policy in relation to making, handling, and investigating complaints, which was last reviewed in May 2017. The approved centre also adopted the HSE’s Your Service Your Say complaints procedure. The policy and procedure included all of the requirements of the Judgement Support Framework.

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

Monitoring: An audit of the complaint management process was completed in May 2017. On foot of the findings of the audit the contact details of the complaints officer was detailed and displayed.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner using the Your Service, Your Say procedure. The ways in which residents and their representatives could lodge complaints were detailed in Your Service, Your Say. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. Information on complaints procedures was included in the resident information booklet and in notices in the approved centre, and copies of Your Service Your Say leaflets were readily available.
While no complaints about the approved centre or its staff had been received since the 2016 inspection, the approved centre used a complaints record to record any minor complaints and a method for addressing minor complaints was in place.

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 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:
   - The identification and assessment of risks throughout the approved centre;
   - The precautions in place to control the risks identified;
   - 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;
   - Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   - Arrangements for responding to emergencies;
   - 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 in relation to risk management procedures, which was dated March 2017. It addressed requirements of the Judgement Support Framework, including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring of risks in the approved centre.
- Rating identified risks.
- Controlling risks such as resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents of the approved centre.
- Responding to emergencies.

The policies did not reference the protection of children and vulnerable adults in the care of the approved centre.

**Training and Education:** Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management, and management staff were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff signed a log indicating that they had read and understood the risk management policy. Staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.
**Monitoring:** The risk register had not been audited at least quarterly to determine compliance with the approved centre’s risk management policies. Analysis of incident reports to identify opportunities for improving risk management processes had been completed.

**Evidence of Implementation:** The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register.

Risks were not being logged because there was no local risk register in place. Health and safety risks were not identified, assessed, treated, reported, and monitored. Structural risks, including ligature points, had not been removed or mitigated. As the approved centre were admitting residents with mood disturbance with possible associated higher risk of suicide, the approved centre ligatures were now more of a risk. Therefore, a ligature audit completed in 2016 did not take account of changes to the approved centre’s resident profile.

The clinical files indicated that the approved centre completed resident risk assessments at admission to identify individual risk factors. Assessments were also completed prior to resident transfer and discharge and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of risk management processes, as did residents and/or their representatives. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using the National Incident Management System. Clinical incidents were reviewed by the MDT at their regular meetings. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. The approved centre had an emergency plan that included evacuation procedures.

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

a) The current risks were not being logged in a local risk register, meaning that the risk management policy was not being implemented throughout the approved centre, 32(1).

b) The risk management policy did not reference arrangements for the protection of children and vulnerable adults from abuse, 32(2)(f).

c) Ligature anchor points were not sufficiently mitigated so as to reduce risk, 32(1).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
### Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, 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

As the approved centre did not use seclusion, this rule was not applicable.
Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

As mechanical means of bodily restraint had not been used in the approved centre since the 2016 inspection, 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
Part 4 Consent to Treatment

56. In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where—
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either—
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent—
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

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

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either—
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

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

INSPECTION FINDINGS

As there was no involuntary patient in the approved centre for more than three months and in continued receipt of medication, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
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: The approved centre had a written policy on the use of physical restraint, dated May 2016 – June 2017. The policy had been reviewed annually and included details of the following:

- The provision of information to residents regarding physical restraint.
- The individuals authorised to initiate and conduct physical restraint.
- The training requirements relating to physical restraint.

Training and Education: All staff had signed a log indicating that they had read and understood the policy. Staff training procedures specified who should receive training, areas to be addressed during training, frequency of training, the identification of appropriately qualified individuals to deliver training, and the mandatory nature of training. A record of attendance at training was maintained. Physical restraint was never used to ameliorate staff shortages.

As there had been no episodes of physical restraint in the approved centre since the 2016 inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this 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

As the approved centre did not admit children, this code of practice was not applicable.
Notification of Deaths and Incident Reporting

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

INSPECTION FINDINGS

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

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

Monitoring: Deaths and incidents in the approved centre were reviewed to identify and correct any problems as they arose and to improve quality.

Evidence of Implementation: The approved centre was non-compliant with Regulation 32: Risk Management Procedures. It used the National Incident Management System to record incidents, and the standard form was available to the inspector. A six-monthly summary of all incidents was sent to the MHC.

There had been two deaths of residents of the approved centre since the last inspection. Both were reported to the MHC within the required 48-hour time frame.

The approved centre was not compliant with this code of practice because it did not comply with Regulation 32: Risk Management Procedures.
INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to working with people with an intellectual disability, which was dated May 2017. The policy reflected person-centred treatment planning, presumption of capacity, and least restrictive interventions. It contained details of the following:

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

Training and Education: Staff had received training in person-centred approaches, relevant human rights principles, and preventative and responsive approaches to problem behaviours.

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

Evidence of Implementation: During the inspection, there was one resident in the approved centre who was diagnosed with dementia and an intellectual disability. There was an appropriate individual care plan in place, which included details of the following:

- The levels of support and treatment required.
- Assessed needs and available resources and supports.
- Consideration of the environment.
- The involvement of the individual’s family.

The resident had a comprehensive assessment. This included an evaluation of performance capacities and difficulties; communication issues; medication history; medical, psychiatric, and psychosocial history; and social, interpersonal, and physical environment issues. The resident’s preferred way of giving and receiving information was established, and information provided was appropriate and accessible. Opportunities were made available for the resident’s engagement in meaningful activities.

The approved centre was compliant with this code of practice.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.
### Admission, Transfer and Discharge

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

### INSPECTION FINDINGS

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

**Admission:** The admission policy addressed all of the criteria of this code of practice, including processes relating to voluntary admissions such as pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. It contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams. There was a policy on confidentiality, privacy, and consent.

**Transfer:** The transfer policy detailed how a transfer was arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary and emergency transfer, and it addressed the safety of the resident and staff during a transfer. It did not include a provision for the transfer of a resident abroad.

**Discharge:** The discharge policy referenced prescriptions and supply of medication on discharge and documented the roles and responsibilities of staff in relation to providing follow-up care. It included protocols for discharging involuntary patients, homeless people, older persons, and people with an intellectual disability. The policy included procedures for managing the discharge of involuntary patients.

The policy’s follow-up procedures did not reference relapse prevention, crisis management, when and how much follow-up contact residents should have, or a way of following up and managing missed appointments.

**Training and Education:** There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge.

**Monitoring:** There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.

**Evidence of Implementation:**

**Admission:** The clinical files of two residents were inspected in relation to admission. These indicated that the approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by a registered medical practitioner (RMP). A comprehensive admission assessment was completed.
and documented in both cases, and assessments and examinations were recorded in the clinical files. Family members/carers were involved in the admission process. Residents were admitted to a unit that was appropriate to their needs.

The approved centre’s admission process was compliant under Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records. It did not comply under Regulation 15: Individual Care Plan.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. The files of two recently transferred residents were inspected. The decision to transfer was made by the RMP and a pre-transfer assessment was undertaken. Family members/carers/advocates were involved in the transfer process, as were members of the MDT. Referral letters were sent to the receiving facility, and copies were retained in the clinical files.

**Discharge:** The clinical file of one recently discharged resident was inspected. The decision to discharge was taken by the RMP. The resident had a comprehensive assessment prior to discharge and there was appropriate MDT input into discharge planning. The discharge was coordinated by the key worker. Efforts were made to inform primary care/community mental health care teams of the discharge within 24 hours. Preliminary discharge summaries were issued within three days, and comprehensive summaries followed within 14 days. The file evidenced the involvement of family/carers/advocates in the discharge process.

The admission, transfer, and discharge procedures were not complaint because the approved centre did not comply with Regulation 32: Risk Management Procedures.

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

- a) The transfer policy did not include provisions for a transfer abroad, 4.13.
- b) The discharge policy’s follow-up procedures did not address relapse prevention, crisis management, when and how much follow-up contact residents should have, or a way of following up and managing missed appointments, 4.14.
- c) There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge, 9.1.
- d) There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.
- e) The approved centre was non-compliant with Regulation 32: Risk Management Procedures, 7.1.
- f) The admission process was non-compliant under Regulation 15: Individual Care Plan, 17.1.
## Appendix 1: Corrective and Preventative Action Plan Template – St Anne’s Unit, Sacred Heart Hospital

### Regulation 15: Individual Care Plan

*Report reference: Page 29-30*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| Taken from the inspection report                             | Reoccurring\(^1\) or New\(^2\) area of non-compliance | Provide corrective and preventative action(s) to address the area of non-compliance | Provide the method of monitoring the implementation of the action(s)               | Provide details of any barriers to the implementation of the action(s)                  | Provide the timeframe of the completion of the action(s) |}

1. In four cases, the full ICP was not developed by the MDT following admission until after the first MDT meeting (held monthly); therefore ICP’s were not regularly reviewed and updated.

   **New**

   **Plan required**

   **Corrective Action(s):**
   - Post-Holder(s) responsible: Initial care plans are only valid for 7 days following admission. A full ICP must then be in place – completed by MDT.
   - All care plans were reviewed by MDT and full ICP’s were in place by day 7.
   - Preventative Action(s):
     - Post-Holder(s) responsible: All ICP’s are now reviewed weekly by CNMIII
     - Audited monthly by MDT
   - None
   - Completed 22/06/17

2. One ICP did not specify the resident’s goals.

   **New**

   **Plan required**

   **Corrective Action(s):**
   - Amend documentation
   - Post-Holder(s) responsible: CNMIII
   - Documentation has been changed & also the audit tool now
   - None
   - Completed 22/06/17

---

1. Area of non-compliance reoccurring from 2016
2. Area of non-compliance not reoccurring from 2016
3. Not applicable
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</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(^2) 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>New plan; plan carried over from 2016; or monitored as per Condition(^3)</td>
<td></td>
<td>includes ‘resident’s goals’</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly audit by MDT &amp; CNMIII</td>
<td></td>
<td></td>
<td>Completed 22/06/17</td>
</tr>
<tr>
<td>3. One ICP did not specify details of the interventions that were in place for residents.</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>ICP documentation templates were amended to include specific interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan required</td>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Documentation to be amended</td>
<td></td>
<td></td>
<td>Completed 22/06/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly MDT audit</td>
<td></td>
<td></td>
<td>Completed 22/06/17</td>
</tr>
<tr>
<td>4. Two ICP’s developed by the MDT failed to document any evidence that the preparation and review of the ICP had been undertaken (as far as reasonably practicable) in consultation with the resident, including involvement of family where appropriate.</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>ICP documentation templates were amended to include carer/family involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan required</td>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td></td>
<td>Completed 22/06/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Documentation to be amended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s):</td>
<td></td>
<td></td>
<td>Completed 29/08/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly MDT audit</td>
<td></td>
<td></td>
<td>Completed 29/08/17</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</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>New plan; plan carried over from 2016; or monitored as per Condition</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. Ligature points had not been minimised.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s):&lt;br&gt;Post-Holder(s) responsible: Re-audit</td>
<td>A full MDT re-audit was undertaken 03/07/17 which found no change in patient profile, therefore, the Approved Centre was fully compliant.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s):&lt;br&gt;Post-Holder(s) responsible:</td>
<td>Review patient profile when scoring risk, should the Unit receive non-dementia admissions. ADON &amp; CNMIII</td>
<td>Monthly reviews commenced 03/08/17</td>
</tr>
</tbody>
</table>

5. Ligature points had not been minimised.

- **Corrective Action(s):**
  - Post-Holder(s) responsible: Re-audit
  - A full MDT re-audit was undertaken 03/07/17 which found no change in patient profile, therefore, the Approved Centre was fully compliant.

- **Preventative Action(s):**
  - Review patient profile when scoring risk, should the Unit receive non-dementia admissions. ADON & CNMIII
  - None
  - Monthly reviews commenced 03/08/17
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>6. Not all staff had up-to-date mandatory training in fire safety, BLS, PMAV, and the MHA 2001.</td>
<td>Reoccurring [for fire safety and BLS]</td>
<td>Plan required</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Extra training dates</td>
<td>New dates have been published for all mandatory training</td>
<td>None</td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible:</td>
<td>CNMII &amp; CNMIII to review monthly and staff will be rostered directly on study days</td>
<td>None</td>
<td>Dec 2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 32: Risk Management Procedures (and Code of Practice: Notification of Deaths and Incident Reporting)

*Report reference: Page 53-54 and 66*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
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<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>
<td></td>
</tr>
<tr>
<td>7. The current risks were not being logged in a local risk register, meaning that the risk management policy was not being implemented throughout the approved centre.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Log all risks locally</td>
<td>Local risk register was commenced and is reviewed monthly by MDT. This is stored electronically on a shared JSF drive for all staff to access.</td>
<td>None</td>
<td>Completed 03/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII to lead &amp; update the register monthly</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The risk management policy did not reference arrangements for the protection of children and vulnerable adults from abuse.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Review the policy</td>
<td>AMT to liaise with Risk Manager &amp; review the policy</td>
<td>None</td>
<td>Dec 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII to link with Risk Manager &amp; Policy Steering Group</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Ligature anchor points were not sufficiently mitigated so as to reduce risk.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: See above re-audit</td>
<td>None</td>
<td></td>
<td>Completed 03/07/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Reg 22 is fully compliant</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Code of Practice: Admission, Transfer and Discharge

**Report reference: Page 69-70**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
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<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>New plan; plan carried over from 2016; or monitored as per Condition</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>
</tbody>
</table>

10. The transfer policy did not include provisions for a transfer abroad.

11. The discharge policy’s follow-up procedures did not address relapse prevention, crisis management, when and how much follow-up contact residents should have, or a way of following up and managing missed appointments.

<table>
<thead>
<tr>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring [for discharge policy]</td>
<td>Plan required</td>
<td>Corrective Action(s): Post-Holder(s) responsible:</td>
<td>Policy was reviewed &amp; amended</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible:</td>
<td>Review required by AMT &amp; Policy Steering Group</td>
<td>None</td>
</tr>
</tbody>
</table>

12. There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge.

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Post-Holder(s) responsible: All staff to read the electronic policy</td>
<td>CNMII &amp; CNMIII to review staff adherence monthly. A further PC has been installed.</td>
<td>None</td>
<td>Dec 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible:</td>
<td>Monthly IT reports are available to view adherence</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</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>
</tbody>
</table>

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

| New | Plan required | Corrective Action(s): Post-Holder(s) responsible: MDT group to be set up | MDT to research & finalise an audit tool | None | Q1 2018 |
| Preventative Action(s): Post-Holder(s) responsible: | Annual audit | None | Q1 2018 |