St. Gabriel's Ward, St. Canice's Hospital

ID Number: AC0017

2017 Approved Centre Inspection Report (Mental Health Act 2001)

St. Gabriel's Ward
St. Canice's Hospital
Dublin Road
Kilkenny

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, General Manager, CHO5

Inspection Team:
Dr Ann Marie Murray, MCRN363031, Lead Inspector
Dr Enda Dooley, MCRN004155
Mary Connellan

Inspection Date:
16 – 19 May 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
26 – 28 July 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
14 December 2017

COMPLIANCE RATINGS 2017

REGULATIONS
3
Compliant
9
Non-compliant
19
Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001
1
Compliant

CODES OF PRACTICE
3
Compliant
3
Non-compliant
3
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.
2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services

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 place in relation to the health and safety of residents, staff, and visitors and a site-specific safety statement was in place. There was a written policy, in relation to risk and incident management processes and this was implemented throughout the approved centre. Appropriate resident identifiers were used before the administration of medications, medical investigations, the provision of therapeutic services and programmes, and the provision of other health care services. Food safety audits were not periodically undertaken. A high standard of hygiene was maintained in relation to the storage, preparation, and disposal of food and related refuse. The approved centre had a written operational policy, on the ordering, prescribing, storing, and administration of medicines, except that the procedure for authorising the crushing of medication was not clearly documented. Not all health care professionals were up to date with training in fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act 2001.

AREAS REFERRED TO

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

Appropriate care and treatment of residents

Each resident had an individual care plan (ICP) which was developed by the multidisciplinary team following a comprehensive assessment. Each ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The resident had access to the ICP, was kept informed of any changes, and was offered a copy of their ICP where appropriate. Therapeutic services were evidence-based, appropriate, and met the needs of the residents. There was no psychology input into the development of therapeutic programmes for residents. Residents’ general health needs were assessed at admission, on an ongoing basis as indicated by their individual care plan and not less than every six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. All residents’ records were secure, up to date and in good order.

Menus were not approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents who had special nutritional requirements did not have access to a dietitian. Residents had access
to a speech and language therapist. End of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. There was non-compliance with the Rule Governing the Use of Mechanical Restraint. The approved centre was compliant with all but one of the elements of the code of practice on physical restraint. It was not compliant with code of practice on admission, transfer and discharge.

**Respect for residents’ privacy and dignity**

Residents had an adequate supply of their own clothing, which showed due regard to their dignity and bodily integrity. They were supported to manage their own property, and secure facilities were available for the safe-keeping of residents’ monies and valuables. There was no process for residents or their representatives to countersign the access and use of residents’ monies. In two shared bedrooms, three curtains did not reach all of the way around the beds to provide adequate privacy for the residents. In another shared bedroom, one bed did not have a curtain around it. There was a broken lock on a residents’ bathroom door.

**Responsiveness to residents’ needs**

Residents had access to varied recreational activities on weekdays and at weekends. There was an activities nurse on duty Monday – Friday, with input from the social worker and occupational therapy staff. Opportunities were provided for indoor and outdoor exercise and physical activity. Residents were served only one single set meal for their main meal at lunchtime and were not consulted regarding their meal choice. Residents’ rights to practice religion were facilitated. Separate visiting areas were provided where residents could meet visitors in private. Residents were free to communicate using mail, fax, e-mail, telephone, and Internet. A new information leaflet had been introduced since the last inspection. The leaflet included information on housekeeping arrangements, arrangements for personal property and mealtimes, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents’ rights. Residents were provided with details of their multi-disciplinary team. Information on diagnosis and medication was provided to each resident.

The approved centre was kept in a good state of repair externally but not internally. The sitting room walls did not reach the ceiling, which led to excessive noise coming from the radio in the adjacent corridor. The only furniture in the sitting room was a torn two-seater sofa. A broken apron dispenser in the corridor presented as a hazard due to sharp uneven edges, and there was a broken curtain rail hanging down in a shared bedroom. There was a missing wardrobe door in a shared bedroom and a broken toilet roll holder in
the en suite facility of a shared bedroom. There were stains on ceiling panels in the day room and in the visitors’ room. Heating was controlled centrally and could not be controlled in the resident’s own room. The approved centre was clean, hygienic, and free from offensive odours. The complaints procedure was displayed.

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

**Governance of the approved centre**

St. Gabriel’s ward was part of the management structure of the Community Healthcare Organisation (CHO) 5 in the HSE, and was part of the Carlow/Kilkenny/South Tipperary governance structure.

There was a recent appointment of a service user lead at executive management team meetings. The Executive Management Team met on a monthly basis.

There were regular St. Gabriel’s ward operational management group meetings attended by senior clinical staff and a service user representative. Quality & Safety Executive Committee meetings were attended by clinical and managerial staff and occurred monthly.

All heads of discipline had clear reporting systems and line management processes in place. Not all heads of department had clear strategic aims for the approved centre or clear processes for monitoring departmental and staff performance. All heads of discipline reported that there were processes in place for peer support and review. Policies were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines.

The operating policies and procedures were not appropriately approved. Many of the policies had extensions, denoted by a handwritten “approval extended”, which was not the approved centre’s agreed procedure for approving policies. Five operating policies and procedures required by the regulations were not reviewed within three years.

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

The following quality initiatives were identified on this inspection:

1. Development of a checklist to review episodes of physical restraint.
2. Development of a checklist to review the discharge process.
3. The introduction of a novel daily record nursing book to improve communication at nursing handover.
4. The introduction of nursing metrics, a tool to analyse the quality of service delivered.
5. The introduction of a memory candle and sympathy card for bereaved family members.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre (St. Gabriel’s Ward) was a 20-bed facility, located on the grounds of St. Canice’s Hospital in Kilkenny. St. Gabriel’s Ward was a single-storey, brick façade building erected in the 1980s. This building also housed separate facilities and offices used by the community mental health teams.

The approved centre comprised a central nurses’ office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two- or three-bed rooms with toilet and shower facilities en suite. A separate single room with no en suite facility was in use at the time of the inspection. The approved centre accommodated residents under the Psychiatry of Later Life and rehabilitation and recovery teams.

The entrance area, corridors, sitting room, and day room had been painted since the last inspection. This provided a bright and fresh backdrop to these areas. There was an attractive garden area, which was purpose-built for the resident profile. Residents were observed to use the garden space under the supervision of nursing staff. Staff were observed to engage with residents in a caring and respectful manner throughout the inspection.

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>20</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>16</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>11</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

St. Gabriel’s ward was part of the management structure of the Community Healthcare Organisation (CHO) 5 in the HSE. The governance of CHO 5 was divided into Carlow/Kilkenny/South Tipperary and Wexford/Waterford. St. Gabriel’s was part of the Carlow/Kilkenny/South Tipperary governance structure.

Minutes of the executive management team (EMT) meetings with responsibility for governance of Carlow/Kilkenny and South Tipperary mental health services were provided to the inspection team. The EMT consisted of heads of discipline, the head of service, and the service manager. They met on a monthly basis. There was minimal specific reference to St. Gabriel’s in these minutes and issues that arose frequently related to the entire Carlow/Kilkenny/South Tipperary area.

There were regular St. Gabriel’s ward operational management group meetings attended by senior clinical staff and a service user representative. These meetings showed clear action points and persons responsible for actions which related specifically to St. Gabriel’s ward. Minutes of Quality & Safety Executive Committee meetings were also provided. These were attended by clinical and managerial staff and occurred monthly.
### 5.0 Compliance

#### 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 26 – 28 July 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 5: Food and Nutrition</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Rule Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Not Applicable</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 5: Food and Nutrition</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>N/A</td>
<td>X</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>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</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

No areas of compliance were rated excellent on this inspection.
6.0 Service-user Experience

Posters and leaflets were displayed in the approved centre inviting residents and their families/representatives to talk to the inspection team. Residents and their family/representatives were also invited to complete a service user experience questionnaire and submit it in confidence to the inspection team. The Irish Advocacy Network representative was contacted to obtain residents’ feedback about the approved centre.

The resident profile in the approved centre was primarily a population of residents in later life with a diagnosis of dementia. No residents chose to speak to the inspection team. One service user experience questionnaire was returned. Family members of three residents chose to speak with the inspection team. The families praised the care their relative had received. The families felt that the staff of the approved centre listened to them and respected them and their relatives. The families praised the dignity and respect shown towards their relatives by the staff, and they highlighted the caring nature of the staff.

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:

- Occupational Therapy Manager
- Principal Social Worker
- Principal Psychologist (Phone interview)
- Clinical Director
- Area Director of Nursing

Not all of the heads of discipline visited the approved centre. When they did visit, it was on a needs-only basis. There was no clinical psychologist assigned to the approved centre; an application had been made for the development of the post by the approved centre. All heads of discipline had clear reporting systems and line management processes in place. There was a recent appointment of a service user lead at executive management team meetings. Not all heads of department had clear strategic aims for the approved centre. Not all disciplines had clear processes for monitoring departmental and staff performance. All heads of discipline reported that there were processes in place for peer support and review.

The heads of discipline reported that it was an ongoing challenge to amalgamate the Carlow/Kilkenny and South Tipperary services. Operational risks reported by the heads of discipline primarily related to issues around staffing, including delays in recruitment, risk of staff retiring early, and insufficient staff numbers. There was a clear effort from all the heads of discipline to engage in quality improvements for the approved centre.
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:

- Social Worker on behalf of Principal Social Worker
- Consultant Psychiatrist x 2
- Occupational Therapist on behalf of Occupational Therapy Manager
- Clinical Director
- General Manager
- Clinical Nurse Manager 2
- Assistant Director of Nursing
- Quality and Patient Safety Manager
- Area Director of Nursing

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

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy dated April 2014 on the identification of residents. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: No relevant staff had signed a log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit was not undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification processes.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used, and these were detailed within the residents’ clinical files. Appropriate resident identifiers were used before the administration of medications, medical investigations, the provision of therapeutic services and programmes, and the provision of other health care services.

The approved centre used photograph, resident name, date of birth, and hospital number as identifiers. The identifiers used were person-specific and did not include room number or physical location. There was a red sticker alert system in place for staff to distinguish between same or similar named residents.

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 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 policy on food and nutrition, dated March 2013. The policy included requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to food and nutrition within the approved centre.
- The monitoring of food and water intake by residents.

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

Monitoring: A systematic review of menu plans was not conducted. Documented analysis was not completed to enhance the food and nutrition processes.

Evidence of Implementation: Menus were not approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents who had special nutritional requirements did not have access to a dietitian. A dietitian had been appointed since the last inspection but was on extended leave at the time of inspection. There was no dietetic replacement appointed during their absence. Residents had access to a speech and language therapist.

The Malnutrition Universal Screen Tool (MUST), a tool to assess nutrition in adults, was introduced since the last inspection. Residents had access to a cold water dispenser and were provided with hot drinks at intervals. Wholesome and nutritious meals were served daily. Residents were not provided with a variety of food choices at mealtimes. Menus included a number of meal options; however, residents were served only one single set meal for their main meal at lunchtime and were not consulted regarding their meal choice.

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

a) Residents were not provided with a choice of meals, 5(2).
b) Residents with special dietary requirements did not have access to a dietitian, 5(2).
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

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

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

Monitoring: Food temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored. Food safety audits were not periodically undertaken. Documented analysis was not completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery to match the specific needs of residents in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. A high standard of hygiene was maintained in relation to the storage, preparation, and disposal of food and related refuse.

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 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated April 2014, in relation to residents’ clothing. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: There were no residents wearing night clothing during daytime hours over the course of the inspection. The availability of an emergency supply of clothing for residents was monitored on an ongoing basis and documented.

Evidence of Implementation: Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plan. Residents were supported to keep and use their personal clothing. Residents had an adequate supply of their own clothing, which showed due regard to their dignity and bodily integrity. No resident required emergency clothing; however, a fund was available to purchase clothes if required. Facilities were available for laundry, where required.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated April 2014 that specified the processes for managing residents’ personal property and possessions. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy. Relevant staff interviewed articulated the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were not monitored. Documented analysis was not completed to identify opportunities to improve the processes for managing residents’ personal property and possessions.

Evidence of Implementation: Residents’ personal property and possessions were safeguarded when the approved centre took responsibility for them. A signed property checklist detailing each resident’s personal property and possessions was maintained. The property checklist was kept separately from the resident’s individual care plan (ICP).

Residents could bring in personal possessions, as agreed with staff, on admission. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Secure facilities were available for the safe-keeping of residents’ monies and valuables.

The access to and use of residents’ monies was overseen by just one staff member rather than two in many instances. There was no process for residents or their representatives to countersign the access and use of residents’ monies.

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 the criteria of the Judgement Support Framework under the training and education pillar, monitoring and evidence of implementation pillars.
## 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 did not have a written policy in relation to the provision of recreational activities.

**Training and Education:** There was no policy in place for staff to read, understand, and articulate.

**Monitoring:** There was a record of the occurrence of planned recreational activities, including a record of resident uptake and attendance. Documented analysis had not been completed to identify opportunities to improve the processes relating to recreational activity.

**Evidence of Implementation:** Residents had access to varied recreational activities. Activities took place on weekdays and, to a lesser extent, during the weekend. A noticeboard in the day room displayed information for residents on the type and frequency of recreational activities in an understandable format. Residents’ decisions to participate, or not, in activities were respected and documented.

Activities included baking, live music once weekly, crosswords, walks, DVDs, and gardening. A seven-seater minibus was used for weekly outings and the daily transportation of residents to mass. The recreational activities provided by the approved centre were appropriately resourced. There was an activities nurse on duty Monday – Friday, with input from the social worker and occupational therapy staff.

Opportunities were provided for indoor and outdoor exercise and physical activity. Chair-based exercises were provided twice weekly. There was a well-maintained garden and sufficient outdoor space for residents to move around. Communal areas provided were suitable for recreational activities; however, the activities room was located separately and distant from the day room.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy, dated May 2016, on the facilitation of religious practices. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The roles and responsibilities in relation to the support of residents’ religious practices.
- The respecting of religious beliefs during the provision of services, care, and treatment.
- The respecting of 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: Not all relevant staff had signed a log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

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

Evidence of Implementation: The care and services that were provided were respectful of the residents’ religious beliefs and values. Residents’ rights to practice religion were facilitated insofar as was practicable. Residents had access to multi-faith chaplains.

Residents were facilitated to observe or abstain from religious practice in accordance with their wishes. The main day room was used to celebrate mass every second Thursday. Residents were accompanied to mass in a local church on most weekdays and on every second Sunday by minibus.

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 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated September 2016, in relation to visits. It included requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

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

Monitoring: At the time of the inspection, there was no restriction on any residents’ rights to receive visitors. Documented analysis had not been completed to identify opportunities to improve visiting processes.

Evidence of Implementation: Visiting times were publicly displayed in the resident information leaflet and on public notices throughout the approved centre. Visiting times were appropriate, reasonable, and flexible.

Separate visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times. The visitor room was suitable for visiting children; however, there were no child-specific facilities such as toys for children to play with.

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, monitoring, and evidence of implementation 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 operational policy, dated January 2014, in relation to communication. The policy included requirements of the *Judgement Support Framework*, with the exception of the following:

- The roles and responsibilities for resident communication processes.
- The assessment of resident communication needs.
- The circumstances in which resident communications may be examined by a senior member of staff.

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

**Monitoring:** Residents’ communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed in order to identify opportunities to improve the communication processes.

**Evidence of Implementation:** Residents were free to communicate using mail, fax, e-mail, telephone, and Internet. Restrictions on communication were individually risk assessed and were documented in each resident’s individual care plan.

There was a hands-free telephone available for use by all residents if required. No resident’s communication required examination by the clinical director or designated senior member of staff.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated January 2015, in relation to the searching of a resident, their belongings, and the environment in which they are accommodated. The policy included all of the requirements of the Judgement Support Framework, including the following:

- The process for the finding of illicit substances during a search.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.

Training and Education: No relevant staff had signed a log to indicate they had read and understood the policy on searches. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy.

As no searches had been undertaken in the approved centre since the last inspection, the approved centre was assessed under the processes and training and education pillars only.

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 two policies in relation to care of the dying. These were The Management of Death, dated June 2015, and End of Life Care Planning Guidelines, dated January 2016. The policies, combined, included requirements of the Judgement Support Framework, with the exception of the process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere (e.g. for general health care services).

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policies.

Monitoring: End of life care provided to residents was systematically reviewed to ensure that it complied with Section 2 of the regulation. No sudden deaths had occurred since the last inspection. Documented analysis was completed to identify opportunities to improve the processes for the care of the dying.

Evidence of Implementation: One death had occurred in the approved centre since the last inspection. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs and was documented in the resident’s individual care plan.

Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of the resident were protected. Representatives, family, next of kin, and friends of the resident were involved, supported, and accommodated during end of life care. The death was reported to the Mental Health Commission within the required 48-hour time frame.

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 15: Individual Care Plan

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy on individual care plans (ICPs) dated June 2015. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members were trained in individual care planning.

Monitoring: Individual care plans were audited on a quarterly basis to assess compliance with the regulation. Documented analysis had been completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: Each resident had an ICP, and 12 of these were inspected. All 12 ICPs were a composite set of documentation.

Each of the 12 residents had been assessed at admission by the admitting clinician and an initial ICP was developed. Each ICP was developed by the MDT following a comprehensive assessment within seven days of admission. Each ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

All 12 ICPs identified appropriate goals, care and treatment, and interventions. Two ICPs did not specify the resources required to provide the care and treatment identified. Instead, the broad term “staff” was used.

All 12 ICPs were reviewed regularly by the MDT in consultation with the resident, where appropriate. There was no psychology input into the development and review of ICPs. The resident had access to the ICP, was kept informed of any changes, and was offered a copy of their ICP where appropriate. As the approved centre did not admit child residents, educational requirements were not applicable.

The approved centre was non-compliant with this regulation because the necessary resources to meet residents’ identified needs were not specified in two ICPs.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to therapeutic services and programmes.

Training and Education: There was no policy for all clinical staff to read, understand, and articulate.

Monitoring: There was no evidence of ongoing monitoring of the range of services and programmes provided to ensure that they met the assessed needs of residents. Documented analysis had not been completed to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: While a board displayed a list of the recreational and therapeutic activities provided on a daily basis, there was no specific list available to residents that identified all therapeutic services and programmes provided within the approved centre.

The therapeutic services and programmes provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. They were evidence-based, appropriate, and met the needs of the residents, as documented in their individual care plans (ICPs). However, there was no psychology input into the development of therapeutic programmes for residents.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, but the activities room was not in close proximity to the day room, which was not ideal for a population of residents in later life.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes within each resident’s ICP or clinical file.

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

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 operational policy, dated October 2015, in relation to the transfer of residents. The policy included requirements of the *Judgement Support Framework*, with the exception of the following:

- The process for managing resident medications during transfer from the approved centre.
- The process for emergency transfers.

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

Monitoring: A log of transfers was not maintained. Each transfer record was not systematically reviewed to ensure that all relevant information was provided to the receiving facility. No documented analysis of transfer processes had been completed.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was examined. Communication records with the receiving facility were documented, including the reason for the transfer and the resident’s care and treatment plan. The resident was risk-assessed prior to the transfer.

All relevant information about the resident was provided to the receiving facility, including a letter of referral. A resident transfer form was not used by the approved centre. A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, 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 general health and medical emergencies policies, which were last reviewed in February 2014. The policies included requirements of the Judgement Support Framework, with the exception of the following:

- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan.
- The referral process for general health needs of residents.
- The documentation requirements in relation to general health assessments.
- The staff training requirements in relation to Basic Life Support.

Training and Education: No clinical staff members had signed a log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes outlined in the medical emergency policy and the general health care policy.

Monitoring: Resident take-up of national screening programmes was not recorded and monitored. A systematic review was not undertaken to ensure six-monthly reviews of general health needs took place. Documented analysis was not completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had emergency equipment and an Automated External Defibrillator.

Registered medical practitioners assessed residents’ general health needs at admission, on an ongoing basis as indicated by their individual care plan and not less than every six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Information was available to residents regarding national screening programmes. Residents had access to national screening programmes and were referred, as 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 processes, training and education, and monitoring pillars.
Regulation 20: Provision of Information to Residents

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedure in relation to the provision of information to residents, which was last reviewed in January 2014. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The process for identifying the residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.
- The process in place to manage the provision of information to resident representatives, family, and next of kin, as appropriate.

Training and Education: No staff had signed a log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes for providing information to residents.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure the information was appropriate and accurate, particularly where information changed such as information on medication and housekeeping practices. Documented analysis was completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: A new information leaflet had been introduced since the last inspection. Residents were provided with the leaflet at admission. The leaflet included information on housekeeping arrangements, arrangements for personal property and mealtimes, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents’ rights. Residents were provided with details of their multi-disciplinary team (MDT).

Information on diagnosis was provided to each resident unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition.
Medication information sheets, as well as verbal information, were provided to residents. The information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy, dated January 2014, in relation to privacy. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.
- The approved centre’s process to be applied where resident privacy and dignity is not respected by staff.

Training and Education: No staff had signed a log to indicate 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: An annual review of the implementation of the policy had not taken place. Analysis had been completed to identify opportunities to improve the processes relating to residents’ privacy and dignity.

Evidence of Implementation: The way in which staff addressed and interacted with residents was respectful. Residents were observed to be called by their preferred names. Staff were discreet when discussing the residents’ condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, with the exception of a broken lock on a residents’ bathroom door beside the kitchen. All locks had an override function.

Rooms were not overlooked by public areas. All observation panels on doors of treatment rooms and bedrooms had blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make and receive private phone calls.

In two shared bedrooms, three curtains did not reach all of the way around the beds to provide adequate privacy for the residents. In another shared bedroom, one bed did not have a curtain around it.

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

(a) Four beds did not have adequate screening to ensure that the residents’ privacy and dignity were appropriately respected at all times.
(b) The broken lock on a resident bathroom did not ensure that residents’ privacy and dignity were appropriately respected at all times.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a policy, dated June 2013, in relation to premises. The policy included the requirements of the Judgement Support Framework, with the exception of the premises maintenance programme, cleaning programme, and infection control programme.

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

Monitoring: A hygiene audit and a ligature audit had been completed. Documented analysis was completed to identify opportunities to improve the premises.

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. Residents were provided with appropriately sized communal rooms and access to personal space. Accommodation for each resident assured their comfort but not their privacy as four beds did not have adequate screening.

The sitting room walls did not reach the ceiling, which led to excessive noise coming from the radio in the adjacent corridor. The only furniture in the sitting room was a torn two-seater sofa. A broken apron dispenser in the corridor presented as a hazard due to sharp uneven edges, and there was a broken curtain rail hanging down in a shared bedroom. While there were ligature points in the approved centre, there were controls in place to minimise potential risks.

The approved centre was kept in a good state of repair externally but not internally. There was a missing wardrobe door in a shared bedroom and a broken toilet roll holder in the en suite facility of a shared bedroom. There were stains on ceiling panels in the day room and in the visitors’ room.
There was a programme of routine general maintenance of water tanks and decorative maintenance in the form of window cleaning. Records of these were not maintained. Other maintenance was upon request. No records were kept of whether maintenance had received or completed each request. Work was frequently left unfinished. Heating was controlled centrally and could not be controlled in the resident’s own room.

There was a sufficient number of toilets and showers for residents. There was no dedicated examination room. The approved centre was clean, hygienic, and free from offensive odours.

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

(a) The premises were not maintained in good decorative condition due to the missing wardrobe door, the broken toilet roll holder, and the stains on ceiling panels, 22(1)(a).

(b) A programme of routine maintenance and renewal of the fabric and decoration of the premises was not developed and implemented and records of such programme were not maintained, 22(1)(c).

(c) The ripped sofa in the sitting room was not suitable for residents, 22(2).

(d) The broken apron dispenser and curtain rail presented as hazards, which were not maintained with due regard to the safety and well-being of residents, staff, and visitors, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.


INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated March 2015, on the ordering, prescribing, storing, and administration of medicines. The policy included requirements of the Judgement Support Framework, with the following exceptions: the process for crushing medications, the process for medication reconciliation, and the process for reviewing resident medication.

Training and Education: No staff had signed a log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. No documented evidence of training of relevant staff in reporting medication incidents or near misses was provided to the inspection team.

Monitoring: No medication-related incidents had occurred since the last inspection. Quarterly audits had been conducted on the Medication Prescription and Administration Records (MPARs). Analysis was completed to identify opportunities for improvement of medication management processes.

Evidence of Implementation: Each resident had an MPAR, and 14 MPARs were inspected. All MPARs inspected included a record of the following: medications administered, route of medication, dose of medication, and frequency of medication. A record was kept when medication was refused by or withheld from a resident. Controlled drugs were checked by two staff prior to administration. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. Medication was stored securely, and the medication trolley remained locked and was secured in a locked room.

In two MPARs, the allergy status was not recorded. In one MPAR, the prescriber had not documented their Medical Council Registration Number (MCRN). While it was documented on one MPAR that medication was to be crushed, there was no documented reason from the resident’s medical practitioner as to why the medication was to be crushed. Consultation with the pharmacist about the type of preparation to be used when crushing medication was not documented. There was no evidence of an inventory of medications having been conducted on a monthly basis.

The approved centre was non-compliant with Regulation 23(1) for the following reasons:

a) In one MPAR, the prescriber had not documented their MCRN.

b) The procedure for authorising the crushing of medication was not clearly documented.
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 place, dated 2016, in relation to the health and safety of residents, staff, and visitors. An associated site-specific safety statement, dated 2017, was in place. The policy and safety statement, combined, included requirements of the Judgement Support Framework, with the exception of the following:

- Falls prevention initiatives.
- Raising awareness of residents and their visitors to infection control measures.
- The response to sharps or needle stick injuries.
- Specific infection control measures in relation to infection types, e.g. C.difficile, MRSA, Norovirus.

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

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

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

The approved centre was compliant with this regulation.
(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 the approved centre did not use CCTV, 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 policy, dated April 2016, in relation to staffing. It also used the HSE’s Code of Practice Appointment to Positions in the Civil Service and Public Service document. The documents, combined, included the requirements of the Judgement Support Framework, with the exception of the following:

- The methods applied for the communication of the staff rota details to staff.
- The staff performance and evaluation requirements.
- The process for reassignment of staff in response to changing resident needs.
- The process for transferring responsibility from one staff member to another.
- The evaluation of training programmes.
- The required qualifications of training personnel and the evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The number and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis was completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place which demonstrated the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. There was no psychologist available to the residents. The need for psychology had been identified by staff of the approved centre. An application had been made for the development of a psychology post by the approved centre. There was no written staffing plan for the approved centre. Not all health care professionals were up to date with training in the following:

- Fire safety.
- Basic Life Support.
Management of violence and aggression {e.g. Therapeutic Crisis Intervention (TCI) /Professional Management of Aggression and Violence (PMAV)}

- The Mental Health Act 2001.

Staff were trained in accordance with the assessed needs of the resident group profile, and assessed needs of individual residents, as detailed in the staff training plan, with one exception: There was no evidence of training in resident rights.

Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. An appropriately qualified staff member was on duty at all times. This was documented. All staff training was documented and staff training logs were maintained. At least one staff member was trained in Children First.

The Mental Health Act 2001 and Mental Health Commission rules and codes and all other Mental Health Commission documentation and guidance were available to staff throughout 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. Gabriel’s</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0-2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Activities nurse</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

a) Not all health care professionals were up to date with required training in the following, 26(4):
   - Fire safety.
   - Basic Life Support.
   - The management of violence and aggression {e.g. Therapeutic Crisis Intervention (TCI)/Professional Management of Aggression and Violence (PMAV)}.
   - The Mental Health Act 2001.

b) The skill mix of staff was not appropriate to the assessed needs of residents as there was no psychologist, 26(2).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated June 2015, in relation to the maintenance of records. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The required resident record creation and content.
- Those authorised to access and make entries in the residents’ records.
- Record review requirements.
- Residents’ access to resident records.
- The destruction of records.
- The process for making a retrospective entry in residents’ records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed a log to indicate they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes as described in the policy. Not all clinical staff were trained in best-practice record keeping.

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

Evidence of Implementation: All residents’ records were secure, up to date, in good order, and constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and the national guidelines and legislative requirements.

Resident records were reflective of the residents’ current status and the care and treatment being provided. Records were maintained through the use of an identifier that was unique to the resident.

Resident records were developed and maintained to a logical sequence. The records were maintained to ensure ease of retrieval. Records were complete and in good order with no loose pages. Entries were
factual, consistent and accurate. Hand-written records were legible and written in black ink. Each record entry did not include the date and the time using the 24-hour clock.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non-compliant with this regulation because the processes for the creation of, access to, and destruction of records were not outlined in the policy, 27(2).
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 an up-to-date, hard copy register of residents. It was available to the Mental Health Commission during the inspection. The register included the information specified in Schedule 1 to the Mental Health Act 2001, with one exception: nine entries did not record the residents’ diagnosis on admission.

The approved centre was non-compliant with this regulation because the diagnosis on admission was not recorded for nine residents, 28(2).
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 two out-of-date written policies in relation to the development, management, and review of operating policies and procedures. These were Operating Policies and Procedures – Document Control Policy, which was last reviewed in 2010, and a Terms of Reference policy, dated April 2014.

The policies included requirements of the Judgement Support Framework, with the following exceptions:

- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The Operating Policies and Procedures – Document Control Policy did not outline the process for making obsolete and retaining previous versions of operating policies and procedures.

Training and Education: There was no signature log for staff to sign to indicate that they had read and understood the policies. Not all relevant staff were trained on approved operational policies and procedures. Relevant staff could articulate the processes for developing and reviewing operational policies, as set out in the policies.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis was conducted to identify opportunities to improve the processes for developing and reviewing policies.

Evidence of Implementation: Policies were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines.

The operating policies and procedures were not appropriately approved. Many of the policies had extensions, denoted by a handwritten “approval extended”. This was not the approved centre’s agreed procedure for approving policies.

Five operating policies and procedures required by the regulations were not reviewed within three years: Regulation 8: Residents’ Personal Property and Possessions, Regulation 12: Communication, Regulation 19: General Health, Regulation 20: Provision of Information to Residents, and Regulation 31: Complaints Procedures.

Obsolete versions of operating policies and procedures were retained but not removed from possible access by staff. There was an obsolete copy of the policy on risk management in the policy folder provided to the inspection team.

Any generic policies used were appropriate to the approved centre and the resident group profile.
The approved centre was non-compliant with this regulation because not all written operational policies and procedures were reviewed at least every three years having due regard to any recommendations made by the Inspector or the Commission.
Regulation 30: Mental Health Tribunals

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

INSPECTION FINDINGS

As there were no detained patients in the approved centre 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 operational policy, dated April 2014, in relation to the management of complaints. It also used the HSE's Your Service, Your Say complaints policy. Combined, the policies included requirements of the Judgement Support Framework, with the exception of the following:

- The confidentiality requirements in relation to complaints.
- The time frames for complaint management, including the time frame for the approved centre to respond to the complaint and for the complaint to be resolved.
- The process to escalate complaints that cannot be addressed by the nominated person.
- The appeal process available where the complainant is dissatisfied with the outcome of the complaint investigation.

Training and Education: Relevant staff were trained on the complaints management process. Not all staff had signed a log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policies.

Monitoring: Audits of the complaints log and related records were completed. Complaints data was analysed and details of this analysis were considered by senior management.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre and was in the resident information leaflet. A consistent and standardised approach was implemented for the management of all complaints.
A method for addressing minor complaints within the approved centre was provided. One minor complaint, including the outcome, had been documented in the local complaints log. This was investigated promptly and handled appropriately and sensitively. Since the last inspection, no complaints were made that were not minor. Therefore, not all aspects of this regulation under the evidence of implementation pillar were applicable and there was no quality assessment of this regulation.

The approved centre was compliant with this regulation.
Regulation 32: Risk Management Procedures

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated June 2016, in relation to risk and incident management processes. The policy included requirements of the regulation and the Judgement Support Framework, with the exception of the following:

- The responsibilities of the registered proprietor.
- The person responsible for the completion of six-monthly incident summary reports.
- Capacity risks relating to the number of residents in the approved centre.
- The process for notifying the Mental Health Commission about incidents involving residents of the approved centre.

Training and Education: Relevant staff were trained in the identification, assessment, and management of risk. Staff were trained in health and safety risk management. Clinical staff were trained in individual risk management processes. Management staff were not trained in organisational risk management. Not all staff members had received training in incident reporting and documentation. All training was documented. Not all staff had signed a log to indicate that they had read and understood the policy. Not all staff interviewed could articulate the risk management processes, as set out in the policy.

Monitoring: While there was a risk register validation process in place, the risk register was not audited to determine compliance with the approved centre’s risk management policy. All incidents in the approved centre were recorded and risk-rated.

Evidence of Implementation: The risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Clinical risks were identified, assessed, treated, reported, and monitored. Clinical risks were documented in the risk register as appropriate. Health and
Safety risks were identified, assessed, treated, reported, and monitored by the approved centre in accordance with relevant legislation. Health and safety risks were documented within the risk register, as appropriate. Corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register.

While there were ligature points in the approved centre, there were controls in place to minimise the potential risks. Individual risk assessments were completed prior to and during episodes of physical restraint and mechanical restraint, at admission to identify individual risk factors, prior to transfer and discharge, and in conjunction with medication requirements or administration. Risk assessment forms were completed and reviewed, but the responsibility of specific staff to review these was not formally assigned. The person with responsibility for risk was not identified and not known by all staff.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format using the National Incident Management System. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. There was an emergency plan in place that specified responses by the staff and incorporated evacuation 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, training and education, monitoring, and evidence of implementation pillars.
## Regulation 33: Insurance

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

### INSPECTION FINDINGS

The approved centre had up-to-date insurance, which covered public liability, employers’ liability, clinical indemnity, and property.

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: The clinical files of two residents who had been mechanically restrained were inspected. In both cases, mechanical restraint was ordered by a registered medical practitioner under the supervision of the responsible consultant psychiatrist or by the responsible consultant psychiatrist. The type of mechanical restraint and the duration of the order was documented. A review date of the order was recorded. The contemporaneous record detailed in the two clinical files did not document the following:

- That there was an enduring risk of harm to self or others.
- That less restrictive alternatives were implemented without success.
- The duration of the mechanical restraint.

The approved centre was non-compliant with this rule as two clinical files did not document the following:

(a) That there was an enduring risk of harm to self or others, 21.5(a).
(b) That less restrictive alternatives were implemented without success, 21.5(b).
(c) The duration of the mechanical restraint, 21.5(e).
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 were no involuntary residents in the approved centre, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
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. The policy was reviewed annually. The staffing policy, dated April 2016, outlined the training requirements of this code of practice. Together, both policies included all of the applicable requirements of this code of practice.

Training and Education: Not all staff had signed a log to indicate that they had read and understood the policy on physical restraint. A record of attendance at training in the prevention and management of aggression and violence was maintained.

Monitoring: The approved centre completed an annual report on the use of physical restraint.

Evidence of Implementation: Physical restraint was never used to ameliorate staff shortages. The clinical file of one resident who had been physically restrained was inspected. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident’s unsafe behaviour. Cultural awareness and gender sensitivity were demonstrated. The resident was informed of the reasons for, duration of, and circumstances leading to the discontinuation of physical restraint. The episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode.

The approved centre was non-compliant with this code of practice because not all staff involved in physical restraint had signed a log to indicate that they had read and understood the policy, 9.2(b).
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 have any children registered as residents at the time of inspection, 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: There was a risk management policy, dated June 2016; a policy on the management of deaths, dated June 2015; and a national safety incident management policy, dated 2014. The policies, combined, detailed all of the requirements of this code of practice with the exception of the roles and responsibilities in the completion of six-monthly incident summary reports.

Training and Education: Staff interviewed were able to articulate the policy requirements.

Monitoring: Deaths and incidents were reviewed to identify and correct any problems and improve the quality of processes.

Evidence of Implementation: The approved centre was compliant with Article 32 of the regulations. There was an incident reporting system in place, and a standardised incident report form was used and made available to inspectors. There was one death in the approved centre since the last inspection, which was notified to the Mental Health Commission (MHC) within the required 48-hour time frame. A six-monthly summary of all incidents was provided to the MHC.

The approved centre was non-compliant with this code of practice because the policies did not outline the roles and responsibilities in the completion of six-monthly incident summary reports, 4.3.
Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

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

INSPECTION FINDINGS

As the approved centre did not have any resident who had been diagnosed with an intellectual disability at the time of the inspection, this code of practice was not applicable.
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 written and up-to-date admission, transfer, and discharge policies. The policies included items of the code of practice, with the exception of the following:

- The transfer policy did not include provisions for emergency transfer or transfer abroad.
- The discharge policy did not include the protocol for discharge of people with an intellectual disability.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policies on admissions, transfer, and discharge.

Monitoring: An audit was not undertaken to monitor the implementation of and adherence to the admission and discharge processes.

Evidence of Implementation:
The approved centre was compliant with Regulation 32: Risk Management Procedures.

Admission: The approved centre complied with the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, and Regulation 20: Provision of Information to Residents. The approved centre did not comply with the following regulations associated with this code of practice: Regulation 15: Individual Care Plan and Regulation 27: Maintenance of Records.

The clinical files of three resident admissions were inspected. Each resident was assigned a key worker. An admission assessment was completed in each case. All assessments and examinations were documented in the three clinical files inspected.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical file of one resident who was transferred was inspected. The registered medical practitioner had made the decision to transfer. An assessment, including risk assessment, was carried out prior to the transfer. The multi-disciplinary team were involved in the transfer process. A copy of the referral letter was retained in the resident’s clinical file.

Discharge: The clinical files of two residents who had been discharged were inspected. The decision to discharge was made by a registered medical practitioner. A discharge plan was in place and documented as part of the residents’ individual care plans. Each resident had a comprehensive assessment prior to being discharged.
The approved centre was non-compliant with this code of practice for the following reasons:

a) The transfer policy did not include provisions for emergency transfer and transfer abroad, 4.13.
b) The discharge policy did not include the protocol for discharge of people with an intellectual disability, 4.16.
c) Not all relevant staff had signed a log to indicate that they had read and understood the policies on admissions, transfer, and discharge, 9.1.
d) An audit was not undertaken to monitor the implementation of and adherence of the admission and discharge processes, 4.19.
e) The approved centre was non-compliant with Regulation 15: Individual Care Plan, 17.1.
f) The approved centre was non-compliant with Regulation 27: Maintenance of Records, 22.6.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 5: Food and Nutrition

**Report reference: Page 18**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring</strong> or <strong>New</strong> area of non-compliance</td>
<td><strong>Provide corrective and preventative action(s) to address the area of non-compliance</strong></td>
<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td><strong>1. Residents were not provided with a choice of meals, 5(2).</strong></td>
<td><strong>New</strong></td>
<td>Corrective Action(s): A choice of meals are now provided for the residents. Post-Holder(s) responsible: Catering Supervisor</td>
<td>Menu plan</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): A weekly menu plan will be made available to all residents. Post-Holder(s) responsible:</td>
<td>Menu plan</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td><strong>Reoccurring</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>2. Residents with special dietary requirements did not have access to a dietitian, 5(2).</strong></td>
<td>Corrective Action(s): Resubmit a request to EMT for dietetic input and complete a risk assessment Post-Holder(s) responsible: Service Manager</td>
<td>On minutes of EMT and QSEC</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Resubmit a request to EMT for dietetic input and complete a risk assessment</td>
<td>On minutes of EMT and QSEC</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>

---

1 Area of non-compliance reoccurring from 2016

2 Area of non-compliance not reoccurring from 2016
| Post-Holder(s) responsible: Service Manager |   |   |   |
## Regulation 15: Individual Care Plan

*Report reference: Page 28*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Provided corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
</tbody>
</table>
| **3. The necessary resources to meet residents’ identified needs were not specified in two ICPs** | Corrective Action(s):  
ICPs are reviewed to ensure resources necessary to meet resident’s identified needs are specified.  
Post-Holder(s) responsible:  
All clinical staff | Quartly audit of ICP’s | Achievable and realistic | October 2017 |
| New                                                                                      | Preventative Action(s):  
The necessary resources to meet residents’ identified needs will be specified in all ICP’s  
Post-Holder(s) responsible:  
All clinical staff | Quartly audit of ICP’s | Achievable and realistic | October 2017 |
## Regulation 21: Privacy

Report reference: Page 35

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Four beds did not have adequate screening to ensure that the residents’ privacy and</td>
<td>Corrective Action(s):</td>
<td>Walk Through Review</td>
<td>Achievable and realistic</td>
<td>October 2017</td>
</tr>
<tr>
<td>dignity were appropriately respected at all times.</td>
<td>Screening to ensure that the residents’ privacy and dignity is respected is now in place.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Technical Services / Clinical Nurse Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s):</td>
<td></td>
<td></td>
<td>October 2017</td>
</tr>
<tr>
<td></td>
<td>Regular maintenance checks to ensure screening is in place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The broken lock on a resident bathroom did not ensure that residents’ privacy and</td>
<td>Corrective Action(s):</td>
<td>Walk Through Review</td>
<td>Achievable and realistic</td>
<td>October 2017</td>
</tr>
<tr>
<td>dignity were appropriately respected at all times.</td>
<td>The broken lock on a resident bathroom has been repaired.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Technical services manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s):</td>
<td></td>
<td></td>
<td>October 2017</td>
</tr>
<tr>
<td></td>
<td>Regular maintenance checks will take place to ensure the locking device</td>
<td></td>
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<tr>
<td></td>
<td>on bathrooms doors are working properly.</td>
<td></td>
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<tr>
<td></td>
<td>Post-Holder(s) responsible: Clinical Nurse Manager and Technical Services Manager</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
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<td>------------</td>
</tr>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>6.</strong> The premises were not maintained in good decorative condition due to the missing wardrobe door, the broken toilet roll holder, and the stains on ceiling panels, 22(1)(a).</td>
<td><strong>Corrective Action(s):</strong> The missing wardrobe door, the broken toilet roll holder, and the stains on ceiling panels have been repaired/replaced. Post-Holder(s) responsible: Technical Services</td>
<td>Walk Through Review</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td><strong>Preventative Action(s):</strong> Regular walk through reviews to monitor conditions. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Walk Through Review and maintenance requisitions</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>7.</strong> A programme of routine maintenance and renewal of the fabric and decoration of the premises was not developed and implemented and records of such programme were not maintained, 22(1)(c).</td>
<td><strong>Corrective Action(s):</strong> A programme of routine maintenance and renewal of the fabric and decoration of the premises will be developed. Post-Holder(s) responsible: Services Manager</td>
<td>Records of maintenance programme will be maintained</td>
<td>Achievable and realistic</td>
<td>November 2017</td>
</tr>
<tr>
<td></td>
<td><strong>Preventative Action(s):</strong> A programme of routine maintenance and renewal of the fabric and decoration of the premises will be developed. Post-Holder(s) responsible: Services Manager</td>
<td>Records of maintenance programme will be maintained</td>
<td>Achievable and realistic</td>
<td>March 2018</td>
</tr>
</tbody>
</table>
8. The ripped sofa in the sitting room was not suitable for residents, 22(2).

| Reoccurring [the sitting room was not in good repair] | Corrective Action(s):  
The ripped sofa in the sitting room was removed. A replacement sofa is awaiting delivery.  
Post-Holder(s) responsible: Technical Services |
|------------------------------------------------------|---------------------------------------------------------------------|
| Preventative Action(s):  
Regular walk through reviews to monitor conditions  
Post-Holder(s) responsible: Clinical Nurse Manager |
| Post-Holder(s) responsible: Technical Services |
| Walk Through Review | Achievable and realistic | Complete |

9. The broken apron dispenser and curtain rail presented as hazards, which were not maintained with due regard to the safety and well-being of residents, staff, and visitors, 22(3).

| New | Corrective Action(s):  
The broken apron dispenser and curtain rail have been repaired  
Post-Holder(s) responsible: Technical services manager |
| Preventative Action(s):  
Regular walk through reviews to monitor conditions  
Post-Holder(s) responsible: Clinical Nurse Manager |
| Post-Holder(s) responsible: Clinical Nurse Manager |
| Walk Through Review | Achievable and realistic | Completed |
### Regulation 23: Medication

Report reference: Page 38

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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</tbody>
</table>
| 10. In one MPAR, the prescriber had not documented their MCRN.                              | **Reoccurring**                                                          | Corrective Action(s):  
MCRN numbers are now present on all MPAR  
Post-Holder(s) responsible: All Registered Medical Practitioners | Medication management audit  
QCM audit monthly | Achievable and realistic | Complete |
|                                                                                           | Preventative Action(s):  
NCHD’s are reminded of their requirement to comply with the Ordering, Prescribing, Storing and Administration of Medicines Policy  
Post-Holder(s) responsible: Responsible Consultant Psychiatrist | Medication management audit  
QCM audit monthly | Achievable and realistic | Complete |
| 11. The procedure for authorising the crushing of medication was not clearly documented      | **Reoccurring**                                                          | Corrective action(s):  
The process for authorising the crushing of medication will be added to the Medication Management Policy and presented to QSEC as an addendum for approval.  
Post-holder(s): CHOS policy group / QSEC | Update to policy | Achievable and realistic | November 2017 |
|                                                                                           | Preventative action(s):  
The process for authorising the crushing of medication will be added to the Medication Management Policy and presented to QSEC as an addendum for approval.  
Post-holder(s): CHOS policy group / QSEC | | | | |
## Regulation 26: Staffing

### Report reference: Page 42

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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</tbody>
</table>

### 12. Not all health care professionals were up to date with required training in the following, 26(4):
- Fire safety.
- Basic Life Support.
- The management of violence and aggression
- The Mental Health Act 2001.

#### Reoccurring Corrective Action(s):
- A data base of staff training is in place. Staff of the approved centre are prioritised for Autumn 2017 / Spring 2018 mandatory training
- Post-Holder(s) responsible: Heads of decipline

#### Reoccurring Preventative Action(s):
- Quarterly circulation of training schedules
- Post-Holder(s) responsible: Heads of decipline

#### New Corrective Action(s):
- A business case has been submitted for the recruitment of a Psychologist
- Post-Holder(s) responsible: Service Manager

#### New Preventative Action(s):
- A business case has been submitted for the recruitment of a Psychologist
- Post-Holder(s) responsible: Service Manager

### 13. The skill mix of staff was not appropriate to the assessed needs of residents as there was no psychologist, 26(2).

#### New Corrective Action(s):
- A business case has been submitted for the recruitment of a Psychologist
- Post-Holder(s) responsible: Service Manager

#### New Preventative Action(s):
- A business case has been submitted for the recruitment of a Psychologist
- Post-Holder(s) responsible: Service Manager

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For each action, the table includes the specific details and responsible post-holders, along with the timeframe for completion.
### Regulation 27: Maintenance of Records

*Report reference: Page 44*

<table>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>14. The processes for the creation of, access to, and destruction of records were not outlined in the policy, 27(2).</td>
<td><strong>Reoccurring</strong></td>
<td>Corrective action(s): The processes for the creation of, access to, and destruction of records will be added to the Maintenance of Records Policy and presented to QSEC as an addendum for approval. Post-holder(s): CHOS policy group / QSEC</td>
<td>Review of policy</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative action(s): The processes for the creation of, access to, and destruction of records will be added to the Maintenance of Records Policy and presented to QSEC as an addendum for approval. Post-holder(s): CHOS policy group / QSEC</td>
<td>Review of policy</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
### Regulation 28: Register of Residents

**Report reference: Page 45**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>15. The diagnosis on admission was not recorded for nine residents, 28(2).</strong></td>
<td><strong>Reoccurring</strong></td>
<td><strong>Corrective Action(s):</strong> The diagnosis on admission has been recorded for all residents Post-Holder(s) responsible: CNM2, Consultant Psychiatrist</td>
<td>Review register of residents</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Preventative Action(s):</strong> Clinical staff are reminded to record the diagnosis on admission for all residents. Post-Holder(s) responsible: CNM2, Consultant Psychiatrist</td>
<td>Review register of residents</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
### Regulation 29: Operating Policies and Procedures

**Report reference: Page 46-47**

<table>
<thead>
<tr>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td><strong>16.</strong> Not all written operational policies and procedures were reviewed at least every three years having due regard to any recommendations made by the Inspector or the Commission.</td>
<td>New</td>
<td>Corrective Action(s): The need to review written operational policies at least every three years has been highlighted to the chair of the CHO5 Policy Group. Post-Holder(s) responsible: CHO5 Policy Group / QSEC</td>
<td>Policy review schedule</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action:: All written operational policies and procedures will be reviewed at least every three years having due regard to any recommendations made by the Inspector or the Commission. Post-Holder(s) responsible: CHO5 Policy Group / QSEC</td>
<td>Policy review schedule</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
### Section 69: Rules on the Use of Mechanical Restraint

**Report reference: Page 58**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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<th>Achievable / Realistic</th>
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<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
<td><strong>Provide the timeframe of the completion of the action(s)</strong></td>
</tr>
<tr>
<td>17. That there was an enduring risk of harm to self or others, 21.5(a).</td>
<td>Corrective Action(s): Contemporaneous records on the use of Mechanical Restraint will include where there is an enduring risk of harm to self or others Post-Holder(s) responsible: Consultant Psychiatrist</td>
<td>Documentation review</td>
<td>Achievable and realistic</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Contemporaneous records on the use of Mechanical Restraint will include where there is an enduring risk of harm to self or others Post-Holder(s) responsible: Consultant Psychiatrist</td>
<td>Documentation review</td>
<td>Achievable and realistic</td>
<td>Complete Staff training ongoing</td>
</tr>
<tr>
<td>18. That less restrictive alternatives were implemented without success, 21.5(b).</td>
<td>Corrective Action(s): Contemporaneous records on the use of Mechanical Restraint will document that less restrictive alternatives were implemented without success Post-Holder(s) responsible: Consultant Psychiatrist</td>
<td>Documentation review</td>
<td>Achievable and realistic</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s):</td>
<td>Corrective Action(s):</td>
<td>Achievable and realistic</td>
<td>Complete</td>
</tr>
<tr>
<td>---</td>
<td>------------------------</td>
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</tr>
<tr>
<td></td>
<td>Contemperanous records on the use of Mechanical Restraint will document that leas restrictive alternatives were implemented without success.</td>
<td>Documentation reviewed and updated to include the duration of the mechanical restraint.</td>
<td>Achievable and realistic</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Staff training</td>
<td>Post Holder(s) responsible: Consultant Psychiatrist</td>
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<td></td>
<td>Post-</td>
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<tr>
<td></td>
<td>Holder(s) responsible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultant Psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>The duration of the mechanical restraint, 21.5(e).</td>
<td>Corrective Action(s): Documentation reviewed and updated to include the duration of the mechanical restraint.</td>
<td>Achievable and realistic</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Post Holder (s) responsible: Consultant Psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Preventative Action(s): Contemperanous records on the use of Mechanical Restraint will include the duration of the mechanical restraint.</td>
<td>Achievable and realistic</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: Consultant Psychiatrist</td>
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## Code of Practice: The Use of Physical Restraint

Report reference: Page 62

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
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</table>
| 20. Not all staff involved in physical restraint had signed a log to indicate that they had read and understood the policy, 9.2(b). | Corrective Action(s):  
All staff are reminded to sign the log to indicate that they have read and understood the policy.  
Post-Holder(s) responsible:  
Heads of decipline  
Preventative Action(s):  
All staff are reminded to sign the log to indicate that they have read and understood the policy.  
Post-Holder(s) responsible:  
Heads of decipline: | Policy signature log | Achievable and realistic | October 2017 |
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<td>21. The policies did not outline the roles and responsibilities in the completion of six-monthly incident summary reports, 4.3.</td>
<td>Reoccurring</td>
<td>Update on 2016 plan: The processes for outlining the roles and responsibilities in the completion of six-monthly incident summary reports will be added to the Risk Management Policy and presented to QSEC as an addendum for approval Post-holder(s) CHO5 policy group / QSEC</td>
<td>CHO 5 Policy Review Group</td>
<td>Achievable and realistic</td>
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<td>Preventative action(s): The processes for outlining the roles and responsibilities in the completion of six-monthly incident summary reports will be added to the Risk Management Policy and presented to QSEC as an addendum for approval Post-holder(s) CHO5 policy group / QSEC</td>
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| **22. The transfer policy did not include provisions for emergency transfer and transfer abroad, 4.13.** | Corrective Action(s):  
The provisions for emergency transfer and transfer abroad will be added to the Transfer policy and presented to QSEC as an addendum for approval.  
Post-Holder(s) responsible:  
CHOS policy group / QSEC                                                              | Provide the method of monitoring the implementation of the action(s)     | Achievable and realistic        | November 2017                     |
|                                                                                         | Preventative Action(s):  
The provisions for emergency transfer and transfer abroad will be added to the Transfer policy and presented to QSEC as an addendum for approval.  
Post-Holder(s) responsible:  
CHOS policy group / QSEC                                                              | Provide details of any barriers to the implementation of the action(s)   | Achievable and realistic        | November 2017                     |
| **23. The discharge policy did not include the protocol for discharge of people with an intellectual disability, 4.16.** | Corrective Action(s):  
A protocol for discharge of people with an intellectual disability will be devised, added to the DischargeFrom Approved Centres Policy and presented to QSEC as an addendum for approval.  
Post-Holder(s) responsible:  
CHOS policy group / QSEC                                                              | Policy Review                                                              | Achievable and realistic        | March 2018                        |
<table>
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<tr>
<th>Preventative Action(s):</th>
<th>Post-Holder(s) responsible:</th>
<th>Policy Review</th>
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<td>A protocol for discharge of people with an intellectual disability will be devised, added to the Discharge From Approved Centres Policy and presented to QSEC as an addendum for approval.</td>
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<td>All relevant staff will sign a log to indicate that they had read and understood the policies on admissions, transfer, and discharge.</td>
<td>Heads of Department</td>
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<td>All relevant staff have been reminded to sign a log to indicate that they had read and understood the policies on admissions, transfer, and discharge.</td>
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<tr>
<td>The audit will be monitored and repeated annually</td>
<td>CPC</td>
<td>Audit</td>
<td>Achievable and realistic</td>
<td>March 2018</td>
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24. Not all relevant staff had signed a log to indicate that they had read and understood the policies on admissions, transfer, and discharge, 9.1.

**Reoccurring**

Corrective Action(s): All relevant staff have been reminded to sign a log to indicate that they had read and understood the policies on admissions, transfer, and discharge. Post-Holder(s) responsible: Heads of Department

Policy signature log Achievable and realistic October 2017

Preventative Action(s): All relevant staff will sign a log to indicate that they had read and understood the policies on admissions, transfer, and discharge. Post-Holder(s) responsible: Heads of Department

Signature log Achievable and realistic October 2017

25. An audit was not undertaken to monitor the implementation of and adherence of the admission and discharge processes, 4.19.

**Reoccurring**

Corrective Action(s): The implementation of and adherence of the admission and discharge processes will be audited. Post-Holder(s) responsible: CPC

Audit Achievable and realistic March 2018

Preventative Action(s): The audit will be monitored and repeated annually Post-Holder(s) responsible: CPC

Audit Achievable and realistic Annual review