Units 2, 3, 4, 5, and Unit 8 (Floor 2), St. Stephen's Hospital

ID Number: AC0036

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Units 2, 3, 4, 5, and Unit 8 (Floor 2), St. Stephen's Hospital
Sarsfield Court
Glanmire
Co. Cork

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

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Sinéad Glennon, Head of Mental Health Services, Cork & Kerry

Inspection Team:
Orla O’Neill, Lead Inspector
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Inspection Date: 4 – 7 April 2017
Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 23 – 26 August 2016

The Inspector of Mental Health Services:
Dr. Susan Finnerty MCRN009711

Date of Publication: 28 September 2017

2017 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspector of Mental Health Services  
Dr Susan Finnerty

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

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

Safety

The approved centre had a written policy in relation to health and safety and a safety statement. There was also a separate fire safety procedure, register, and plan. The approved centre had a series of policies in relation to risk management and incident management procedures. Staff were able to articulate the risk management processes, as set out in the policies. At least two person-specific resident identifiers were used. There was documented evidence that food safety audits had been completed and hygiene was maintained to support food safety. There were ligature anchor points observed on all five wards. A ligature audit had not been completed since 2010 and did not reflect the current status of the building. The ordering, prescribing, storage and administration of medication was satisfactory. Staff training records indicated that no staff discipline was fully compliant in relation to required training in fire safety, Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act (MHA) 2001. There was, however, an active training programme in place and most nursing staff had completed training. Staff had received training in Children First. Staff were trained in accordance with the assessed needs of the residents, and additional training had been delivered on manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults.

**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

A campus-wide multi-disciplinary Therapeutic Activities Committee had conducted a needs assessment across all units. The occupational therapist and nurse therapist had undertaken a service user feedback survey in Unit 4 (admission unit) to inform quality improvement and service development. A dietician attended the approved centre weekly and provided input on an individual clinical basis to residents. Residents had an individual care plan (ICP). However, not all ICPs were developed by the multidisciplinary team following the assessment. In Unit 3, residents did not have appropriate ICPs; they had nursing care
plans, which were reviewed by the multidisciplinary team but not updated in line with residents’ changing needs, condition, circumstances, and goals. Not all ICPs contained a specified set of goals, necessary resources to meet identified needs or treatment and care required. ICPs were not consistently completed in consultation with the resident. Two residents with an intellectual disability did not have an appropriate, multi-disciplinary ICP. The range of available, evidence-based programmes was appropriate to the assessed needs of the resident population. The Valley View resource centre on the campus hosted therapeutic programmes. Therapeutic activities were also facilitated by nursing and occupational therapy staff in individual units. Residents in Unit 4 (admission) commented positively about occupational therapy and Valley View resource centre. Residents had access to appropriate general health care services. Residents’ general health needs were not consistently monitored and assessed at least every six months. Not all clinical files were maintained in good order. The approved centre was not compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because the specific medication prescribed to the patients was not recorded on Form 17. The approved centre was compliant with the code of practice on physical restraint. In two files examined, there was no evidence that residents had a physical examination at admission, a requirement of the code of practice.

**AREAS REFERRED TO**


**Respect for residents’ privacy and dignity**

Residents interviewed considered their dignity and privacy to be respected and viewed staff as friendly and respectful. Residents’ clothing was observed to be clean and appropriate to their needs but residents were not consistently supported to keep and wear their personal clothing. In Unit 3, the wardrobes were small and did not provide enough space for residents’ clothing. The clothing store room in the same unit had a large pile of residents’ coats on the floor. Residents retained only a few items of personal clothing as most of the clothing was locked away. There were secure facilities for the safe-keeping of monies, valuables, and personal effects. Privacy and dignity were not respected at all times: not all bathrooms, showers, toilets, and single bedrooms had locks with an override facility; on Unit 3 screening curtains did not fully surround the beds; a number of curtains throughout the approved centre required maintenance; observation panels in shared rooms/wards were not appropriately screened. Resident names and other identifiable information were displayed in the dining room in Unit 8 and in Unit 3, the full names of residents and of allocated key workers were displayed in an area accessible to visitors. This breached confidentiality. Residents on Unit 5 had to use the staff office to make calls, and staff admitted to “keeping an eye” on calls in the office. When an acute bed was required for a new admission, residents from Unit 4 were moved to Unit 8, which compromised their privacy.

**AREAS REFERRED TO**

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

Community outings had now been introduced for residents in Unit 3. Residents were positive in their comments about the quality of meals and choice provided. Residents were provided with a range of wholesome and nutritious food choices which was presented in an attractive and appealing manner. There was access to appropriate recreational activities which were scheduled in the approved centre on weekdays, and outings were organised for the weekends. The activities were appropriately resourced. Residents in Unit 8 did not have ready access to an outdoor space.

Residents were facilitated in the practice of their religion. Visiting times were appropriate and reasonable. Private visiting rooms were available; however, visiting areas were not child-friendly. Residents had access to external communications. Computer and Internet access was available in the nearby Valley View resource centre. Required information was provided to residents through information booklets available on each unit. Residents received written and verbal information about their diagnosis but medication information sheets were available only on request, except in Unit 4, where leaflets and information on mental health were readily available. The complaints process was satisfactory and well-advertised in the approved centre.

The approved centre was not maintained or cleaned in a satisfactory manner. Not all rooms were well ventilated, and there was a malodorous smell in a number of areas. The signage and sensory aids were not always appropriate to support residents’ orientation needs. There was no maintenance schedule for addressing issues that had been identified and reported. The units in the approved centre were not in a good state of repair, either internally or externally. The approved centre was not clean: Units 3 and 5 were dirty, toilets were stained, pedestals were rusty, and faeces was observed on the assistance bars in a toilet on Unit 5. Couches and chairs were worn and some chairs had cigarette burns. It was unacceptable that residents should be living in these conditions.

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

The approved centre was part of the HSE’s Community Healthcare Organisation (CHO) Area 4 Cork/Kerry governance structure. The CHO Area 4 management team met monthly and the head of mental health services sat on this team. The Cork Mental Health Services management team met on a monthly basis. The clinical director of St. Stephen’s Hospital was not a member of this team. There was no quality safety executive committee (QSEC) in place. The approved centre’s management team, the North Cork Mental Health Services management team, met monthly. Senior managers advised that this team did not conduct health and quality walk-arounds. The organisational chart provided for St. Stephen’s Hospital presented a tripartite management structure, with the clinical director, the director of nursing, and the hospital administrator as the senior managers.

Health and social care professionals were depicted as reporting in to the clinical director. Such a governance structure was unusual in 2017 mental health services. Defined lines of responsibility were evident in each department. There were five assistant director of nursing posts within the approved centre, each with responsibility for a different in-patient unit. The inspection team encountered different practices in each of
the five units in relation to décor and general upkeep and in the operation of individual care plans. There did not seem to be any rational reason for such nurse management in one approved centre. Operating policies and procedures were developed with input from clinical, managerial, and multi-disciplinary team staff. Policies were drawn up by the North Cork Mental Health Service Policy, Protocol and Guidelines (PPG) committee, and draft guidelines were developed in consultation with a representative from a service user group such as the Irish Advocacy Network. All policies required by the regulations were reviewed within the required three-year time frame.

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

The following quality initiatives were identified on this inspection:

1. A campus-wide multi-disciplinary Therapeutic Activities Committee had conducted a needs assessment across all units. Therapeutic programmes were being rolled out in accordance with identified needs. There was a varied and comprehensive programme being developed.
2. The occupational therapist and nurse therapist had undertaken a service user feedback survey in Unit 4 (admission) to inform quality improvement and service development.
3. Initiatives undertaken to achieve a tobacco-free campus included staff training and a service user survey and audit.
4. A senior dietician provided input to residents in the approved centre.
5. Art therapy had been introduced in conjunction with Crawford Art College. At the time of inspection, residents were exhibiting their artwork in the “Reflections Through Art” exhibition in Cork airport.
6. Community outings had been introduced for residents in Unit 3.
7. Valley View resource centre had introduced a gardening project.
8. A quarterly food and nutrition meeting had been established. This provided a forum for the dietitian, the speech and language therapist, nursing staff, and catering staff to review quality improvement initiatives for the provision of meals to residents. Training in the use of the St. Andrew’s Nutritional Screening Instrument (SANSI) was being rolled out for all nursing staff.
9. The head of mental health services had hosted a “Listening” meeting with 60 staff to elicit views on service needs.
4.1 Description of approved centre

The approved centre was located within the 117 acre grounds at St. Stephen’s Hospital, Sarsfield’s Court, Glanmire, Co. Cork. St Stephen’s Hospital opened as a sanatorium in 1956 and comprised a large multi-storey main building and several single-storey units. It was situated approximately two kilometres from Glanmire village and seven kilometres from Cork city. There were extensive walkways throughout, as well as a pitch and putt club used by the local community. There was ample parking for visitors and staff.

The approved centre had 93 beds and comprised the following:

- Unit 2 (Psychiatry of Later Life), 25 beds
- Unit 3 (male unit for residents with severe and enduring mental illness), 13 beds.
- Unit 4 (acute admissions unit), 17 beds.
- Unit 5 (male unit for residents with severe and enduring mental illness and challenging behaviour), 13 beds.
- Unit 8 Floor 2 in the main building (residents with enduring mental illness and challenging behaviour), 25 beds.
- Valley View resource centre.

Three general adult sector teams (Fermoy and Mitchelstown, Mallow and Charleville, Kanturk and Newmarket), a Psychiatry of Later life, and a rehabilitation team admitted residents to the approved centre. The Executive Clinical Director had responsibility for a number of residents in Unit 3 and an additional consultant psychiatrist had responsibility for long-stay residents in Unit 8 Floor 2.

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>93</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>76</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>5</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>3</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>60</td>
</tr>
</tbody>
</table>
4.2 Conditions to registration

There were four conditions attached to the registration of this approved centre at the time of inspection:

Condition 1. To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

Condition 2. To ensure adherence to Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines, the approved centre shall audit their Medication Prescription and Administration Records (MPARs) on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

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

Condition 4. To ensure a comprehensive risk management policy is implemented in the approved centre in adherence to Regulation 32(1) and (2), the approved centre shall submit a copy of their risk register to the Mental Health Commission in a form and frequency prescribed by the Commission.

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was a constituent of the HSE’s Community Healthcare Organisation (CHO) Area 4 Cork/Kerry governance structure. The CHO Area 4 management team met monthly and the head of mental health services sat on this team. The Cork Mental Health Services management team met on a monthly basis. The minutes provided for these meetings were variously entitled the Mental Health Business Meeting, the North Cork Mental Health Services Management Meeting or the Cork Mental Health Management Meeting. The clinical director of St. Stephen’s Hospital was not a member of this team. There was no quality safety executive committee (QSEC) in place. The head of mental health services had hosted a “Listening” meeting with 60 staff to elicit views on service needs. Staff commented positively on this initiative.

There were a number of local North Cork mental health services committees. These included:

- The approved centre’s management team, the North Cork Mental Health Services management team, met monthly. The lead inspector requested a copy of the minutes for these meetings. The documents provided gave the impression that the agenda was responsive to issues arising rather than a structured governance rollover agenda. Senior managers advised that this team did not
conduct health and quality walk-abouts. The organisational chart provided for St. Stephen’s Hospital presented a tripartite management structure, with the clinical director, the director of nursing, and the hospital administrator as the senior managers. Health and social care professionals were depicted as reporting in to the clinical director. Such a governance structure was an outlier in 2017 mental health services. The North Cork Mental Health Services Management Team related to the Executive Management Team (EMT) through the area administrator.

- A serious incident management team, which met monthly. This committee communicated with the EMT through the area administrator.
- A North Cork Health and Safety Committee, which met quarterly.
- A Policy Committee.
- A quarterly assistant directors of nursing (ADONs) and clinical nurse managers 3 (CNM3s) approved centre committee was in place. The minutes gave an account of a structured governance forum.

The records of the various governance groups provided to inspectors did not present a clear picture of coherent and integrated governance structure and processes across all committees.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 23 – 26 August 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</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>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 32: Risk Management Procedures</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Admission of Children under the Mental Health Act 2001</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Code of Practice on Notification of Deaths and Incident Reporting</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</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 32: Risk Management Procedures</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 34: Certificate of Registration</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>✓</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

There were no areas rated excellent on this inspection.
6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

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

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

Seven questionnaires were returned to the inspection team. All seven residents considered their dignity and privacy to be respected and knew the identity of their key worker and their multi-disciplinary team and were familiar with their individual care plans.

The IAN representative provided a written report on residents’ views of their experience in the approved centre.

Five residents met with the inspection team. Residents were positive in their comments about the quality of meals and choice provided. Residents also viewed staff as friendly and respectful. Residents knew who their key worker was each day and were aware of having an individual care plan. Residents in Unit 4 (admission) commented positively about occupational therapy and Valley View resource centre. Residents enjoyed going for walks in the grounds and on any organised outings. One resident found the showering facilities in Unit 4 to be inadequate and had requested a flexible rather than a fixed shower hose.
7.0 Interviews with Heads of Discipline

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

- The Clinical Director
- The Area Administrator
- Assistant Directors of Nursing X 2
- The Occupational Therapy Manager
- The Acting Principal Clinical Psychologist
- The Principal Social Worker

All clinical heads of discipline made themselves available to speak with the inspectors. Representatives from nursing, medical, social work, occupational therapy, and psychology each provided a clear overview of the governance within their respective departments. Not all heads of discipline were based in the approved centre. Nevertheless, each head of discipline had good knowledge and familiarity with governance and service delivery within the approved centre.

Defined lines of responsibility were evident in each department. Consequently, staff supervision was facilitated within the departments and regular meetings were scheduled with staff to ensure that they were adequately supported. All heads of discipline identified strategic aims for their teams and discussed potential operational risks with their departments. There were four ADON posts within the approved centre, each with responsibility for a different in-patient unit. The inspection team encountered different practices in each of the five units in relation to décor and general upkeep and in the operation of individual care plans.

A notable feature in St. Stephen’s approved centre was the cohesive multi-disciplinary work being undertaken in relation to service needs evaluation and analysis, and therapeutic programme planning.
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:

- The Clinical Director
- The Area Administrator
- The Area Director of Nursing
- Assistant Directors of Nursing X 3
- The Occupational Therapy Manager
- The Principal Social Worker
- A Consultant Psychiatrist
- A Senior Clinical Psychologist
- A Senior Dietician
- A Senior Pharmacist
- A Staff Officer

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The approved centre continued its practice of moving residents from Unit 4, the acute admissions unit to Unit 8 Floor 2, for the purpose of freeing up a bed for incoming admissions. Such transfers were not in the residents’ best interests and residents had raised their dissatisfaction with this practice with the independent advocate. Discussion at the feedback meeting included: practice of sleeping out, and the flexibility available to the approved centre in terms of bed configuration within units contingent on operating within the overall bed numbers for which they were registered.
EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in November 2015. It included requirements of the Judgement Support Framework, with the exception of the required use of two appropriate resident identifiers prior to the provision of therapeutic services and programmes.

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

Monitoring: An annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Analysis had been completed to identify opportunities for improving the resident identification process and an action plan was in place.

Evidence of Implementation: An inspection of clinical files indicated that at least two person-specific resident identifiers were used, including name and photographs in the long-stay units and name and date of birth in Unit 4. The resident identifiers, which were appropriate to residents’ communication abilities, were checked before the administration of medication, the undertaking of medical investigations, and the provision of health care services. Appropriate resident identifiers were also used prior to the provision of therapeutic services and programmes. An alert sticker system was in place in the Unit 4 to remind staff of the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 5: Food and Nutrition

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents in the approved centre were provided with a range of wholesome and nutritious food choices. There had been no dietetics consultation in the development of the menus. Food was presented in an attractive and appealing manner, and hot meals were provided daily. Residents had access to hot and cold drinks and to safe, fresh drinking water throughout the approved centre. A dietician attended the approved centre weekly and provided input on an individual clinical basis to residents.

The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietician. The Nutrition Care Process Model, an evidence-based nutrition assessment tool, was used in Units 2 and 8. A dietician assessed residents in the other units, when appropriate. Weight charts were implemented, monitored, and acted upon for residents, where necessary.

The approved centre was compliant with this regulation. The quality rating was satisfactory rather than excellent because not all the Judgment Support Framework criteria for monitoring and implementation were in place.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. Food-handling staff in the main kitchen and multi-task assistants had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented. Nursing staff plated the food, but they had not received food safety training.

Monitoring: There was documented evidence that food safety audits had been completed. Food temperatures were recorded in line with food safety recommendations, and a log sheet was maintained. Analysis had not been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: The catering equipment both in the main hospital kitchen and in the unit kitchenettes was suitable and adequate, with appropriate facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety. Appropriate hand-washing areas were in place for catering staff, and catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to clothing, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis via an audit on each of the units. A record of residents wearing nightclothes during the day was kept and monitored.

Evidence of Implementation: Residents’ clothing was observed to be clean and appropriate to their needs. An emergency supply of clothing was available, which took account of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents did not wear nightclothes during the day unless otherwise specified in their individual care plans. All residents had an adequate supply of individualised clothing.

Residents were not consistently supported to keep and wear their personal clothing. In Unit 3, the wardrobes were small and did not provide enough space for residents’ clothing. The clothing store room in the same unit had a large pile of residents’ coats on the floor. In Unit 8, residents retained few items of personal clothing. Most of the clothing was locked away to ensure that people only accessed their own clothing.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation 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 policy in relation to residents’ personal property and possessions, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: Units 3 and 8 did not maintain personal property logs for residents. Analysis had not been completed to identify opportunities for improving the processes around personal property and possessions.

Evidence of Implementation: Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. There were secure facilities for the safe-keeping of monies, valuables, and personal effects in the form of a safe on each unit for money and additional secure storage areas in the administration building. Residents were facilitated in bringing personal property and possessions into the approved centre. The approved centre did not accept responsibility for items not handed in for safe-keeping and did not provide individual secure storage for residents.

Residents were not consistently supported to keep and wear their personal clothing. In Unit 3, the wardrobes were small and did not provide enough space for residents’ clothing. The clothing store room in the same unit had a large pile of residents’ coats on the floor. In Unit 8, residents retained few items of personal clothing. Most of the clothing was locked away to ensure that people only accessed their own clothing.
Two members of staff oversaw the process of providing residents with access to their monies. Each resident had a separate cash envelope, which had fields for recording the date, deposit/withdrawal amounts, balance, nurse’s signature, and resident’s signature.

Property logs were not maintained on all units. Neither Unit 3 nor Unit 8 recorded residents’ property and possessions even though it was reported that residents on Unit 8 took one another’s property.

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

a) Units 3 and 8 did not maintain property logs, 8(3).

b) There was a lack of appropriate, individual storage facilities to support residents to retain control of personal property and possessions, 8(5).
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in November 2015. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities. Resident uptake/attendance was recorded in the clinical files. An audit and analysis had been completed to identify opportunities for improving the processes in relation to recreational activities.

Evidence of Implementation: Residents had access to appropriate recreational activities, and the available resources included reading materials, board games, TV, arts and crafts, a newspaper group, music groups, bingo, gardening, and community outings, where appropriate. Activities were scheduled in the approved centre on weekdays, and outings were organised for the weekends by the nurse therapist.

Information on recreational activities was provided to residents in an accessible format, including the types and frequency of appropriate, meaningful, and purposeful recreational activities. A weekly schedule of activities was displayed on noticeboards in each unit.

Recreational activities were developed, maintained, and implemented with resident involvement. Residents’ views were taken into account during community meetings, and efforts were made to respond positively to requests regarding activities. Where appropriate, individual risk assessments were completed for residents in relation to the selection of appropriate activities.

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Residents in Units 2, 3, 4, and 5 had direct access to outdoor areas; those in Unit 8 did not. There were suitable communal areas for recreation. Residents’ decisions on whether or not to participate in activities were respected. Records of attendance at activities were maintained.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in November 2015. The policy included requirements of the Judgement Support Framework, with the exception of information on the roles and responsibilities of staff in relation to the support of residents’ religious practices.

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

Monitoring: An audit of the policy’s implementation had been completed to ensure that residents’ identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. Mass was held on units, priests visited daily, and multi-faith chaplains visited when required. There was a Catholic church in the approved centre and a Church of Ireland church nearby. Religious services outside the approved centre could be attended by residents, where appropriate and following a risk assessment. Other religious and spiritual needs were also supported.

Residents’ religious needs were assessed on admission, when a risk assessment in relation to religion was also completed. The care and services provided always prioritised residents’ religious preferences, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to visits, which was last reviewed in November 2015. It addressed requirements of the *Judgement Support Framework*, with the exception of the availability of appropriate locations for resident visits and the required visitor identification methods.

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

**Monitoring:** An audit had been completed to identify opportunities for improving visiting processes. An action plan for displaying visiting times more clearly had been put in place. One resident in the approved centre had restrictions on visits, and this was documented by the treating consultant in the clinical file.

**Evidence of Implementation:** Visiting times, which were appropriate and reasonable, were displayed outside each visiting room and detailed in the resident and visitor information booklet. One resident was subject to visiting restrictions at the time of the inspection, and the restrictions were documented by the treating consultant in the clinical file.

Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Visitors were asked to report to the nursing staff on arrival in each unit. Private visiting rooms were available, and children were welcome when accompanied, to ensure their safety. However, visiting areas were not particularly child-friendly.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in November 2015. It included all the requirements of the Judgement Support Framework.

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

Monitoring: There was documentary evidence that residents’ communications needs and restrictions on communication were monitored on an ongoing basis. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to external communications, including post, fax, and telephone. Residents on Unit 4 could retain their mobile phones but were informed that the use of the camera function was prohibited. They also had access to a public phone. In Units 3 and 5, residents did not have phones and were facilitated to make calls in private in an office. Residents in Unit 8 could retain their personal phones and could use an office phone in privacy if necessary. Computer and Internet access was available in the Valley View resource centre.

Where required, individual assessments were completed for residents in relation to risks associated with their external communication. This was documented in the relevant individual care plans. A senior member of staff could examine resident communication only where there was reasonable cause to believe that the communication may result in harm to the resident or others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in March 2017. It covered all of the requirements of the Judgement Support Framework, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she was accommodated.
- The consent requirements of a resident regarding searches and the process for conducting searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.
- The process for communicating the approved centre’s search policies and procedures to residents and staff.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff could articulate the procedures relating to searches, as outlined in the policy.

Monitoring: A log of searches was maintained, but no searches had been conducted in relation to any of the residents of the approved centre since the last inspection. No environmental searches had been conducted.

Evidence of Implementation: Given that no searches had been conducted since the 2016 inspection, the approved centre was not inspected against the evidence of implementation pillar for this regulation.

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 three written policies in relation to the care of the dying, dated November 2015. The policies covered care of the dying, unexpected deaths, and guidelines and procedures in relation to a suspected suicide. They included requirements of the Judgement Support Framework, with the exception of the following:

- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred to another facility.
- Requirements relating to Do Not Attempt Resuscitation orders.

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

Monitoring: Analysis had been completed to identify opportunities to improve the processes relating to care of the dying.

Evidence of Implementation: No deaths had occurred in the approved centre since the date of the last inspection, but one resident had passed away in another facility. The Mental Health Commission (MHC) was not notified of the death within the required 48-hour time frame.

The approved centre was not compliant with this regulation because the death of one resident was not notified to the MHC within the required time frame, 14(4).
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 two written policies in relation to the development, use, and review of individual care plans (ICPs), which were dated November 2015 and June 2014. The policies included all of the requirements of the Judgement Support Framework.

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

Monitoring: ICPs were audited to assess compliance with the regulation, but they were not audited on a quarterly basis, as required. Analysis had been completed to identify opportunities for improving the individual care planning process.

Evidence of Implementation: Forty ICPs were inspected. Each was a composite set of documentation, although each unit used a different ICP template. The ICPs were stored in the clinical file, were identifiable and uninterrupted, and were kept separately from progress notes. Residents received a comprehensive assessment at admission and ICPs were completed by the nursing staff in order to address residents’ immediate needs. Evidence-based assessments were used where possible.

In all cases, a key worker was identified to ensure continuity in the implementation of the ICP, an individual risk management plan was in place, and a preliminary discharge plan was developed, where appropriate. The ICPs were reviewed by the MDT weekly in the acute admission unit and six-monthly in continuing care units. The ICPs recorded whether residents declined or refused a copy of their ICP and why, but there was no evidence that residents had been offered copies of their ICPs.

Not all ICPs were developed by the MDT following the assessment. In Unit 3, residents did not have appropriate ICPs. They had nursing care plans, which were reviewed by the MDT. Also in Unit 3, ICPs were not updated in line with residents’ changing needs, condition, circumstances, and goals.

In six of the ICPs examined, the review page, which detailed needs, goals, interventions, and resources, had not been filled out. One ICP had not been completed within seven days of admission.
Three of the ICPs contained no evidence of family input into care planning, two did not document resident involvement in the process, and seven did not include resident signatures. Two ICPs did not identify residents’ assessed needs, two did not specify appropriate goals, seven did not identify appropriate interventions, and two did not detail the resources required to provide the care and treatment identified.

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

a) Not all ICPs contained a specified set of goals.
b) Not all ICPS clearly identified necessary resources to meet identified needs.
c) ICPs were not consistently completed in consultation with the resident.
d) Not all ICPs were developed by the MDT.
e) Not all ICPs specified the treatment and care required.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to therapeutic services and programmes, dated November 2015. It included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes and was documented.

Evidence of Implementation: The range of available, evidence-based programmes was appropriate to the assessed needs of the resident population, as outlined in individual care plans. The Valley View resource centre hosted therapeutic programmes, including recovery groups, relaxation groups, coping skills groups, music therapy, and art therapy. All residents could access these programmes, based on a risk assessment. Individual units also provided programmes of therapeutic activities that were facilitated by nursing and occupational therapy staff.

The available therapeutic services and programmes sought to restore and maintain optimal levels of physical and psychosocial functioning of residents. Where residents required a service or programme that was not available internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate alternative location or on-site. A weekly therapeutic schedule was displayed on the noticeboard in each unit, and a daily activities schedule was available on some units. In addition to the resources in Valley View, each unit had separate, dedicated facilities for the delivery of therapeutic services and programmes. Residents’ participation and engagement in and the outcomes achieved were documented in their clinical files.

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

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

INSPECTION FINDINGS

As the approved centre had not admitted any children since the 2016 inspection, this regulation was not applicable.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in March 2017. It included requirements of the Judgement Support Framework, with the exception of the process for managing resident medications during a transfer.

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

Monitoring: The approved centre maintained a transfer log, and individual logs were being introduced in all units. There was no evidence that analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who was transferred to A&E at Cork University Hospital was examined. The resident’s consent to transfer was documented in the nursing notes. A pre-transfer medical and psychiatric assessment was undertaken, documented, and forwarded to the receiving facility. Communication with the receiving facility was recorded, and written information regarding the resident was transferred, including a letter of referral with a list of current medications and a list of medications required during the transfer. A resident transfer form was not issued.

The approved centre did not complete a checklist to ensure that comprehensive resident records were transferred to the receiving facility. Copies of all records relevant to the transfer were not retained in the clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the 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 a policy in relation to general health and responding to medical emergencies, which was last reviewed in November 2015. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policy.

Monitoring: There was no evidence that resident take-up of national screening programmes was recorded and monitored. Systematic reviews were undertaken to determine whether six-monthly general health assessments took place, and review folders were in place on all units except the admissions unit. Analysis had been completed to identify opportunities to improve general health processes, and an action plan was in place.

Evidence of Implementation: All units in the approved centre had a resuscitation trolley, which was checked weekly. Staff had access to Automated External Defibrillators, which were checked daily.

The clinical file relating to one medical emergency was inspected. All of the processes outlined in the policy were adhered to and documented, as was the follow-up with the general hospital to which the resident was transferred.

Residents had access to appropriate general health care services, including diabetic care and speech and language therapy, and this was recorded in their individual care plans. Records were maintained of completed general health checks and the associated results. Residents had access to appropriate national screening programmes, but information was not available on the screening provided through the approved centre.

Residents’ general health needs were not consistently monitored and assessed at least every six months: One resident in Unit 2 was overdue a six-monthly physical assessment and two residents in Unit 4 had not had six-monthly physical reviews. Long-term residents did not have access to a general practitioner service.

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH
but were referred to the Mercy Hospital or other general health services. Registrars dealt with all medical issues as they arose.

The approved centre was not compliant with this regulation because not all residents’ general health needs were assessed at least every six months, 19(1)(b).
Regulation 20: Provision of Information to Residents

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

(a) details of the resident’s multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to the provision of information to residents, which was last reviewed in November 2015. It included requirements of the Judgement Support Framework, with the exception of information on the advocacy arrangements for residents.

Training and Education: All staff had signed logs – held on individual units – indicating that they had read and understood the policy. Staff interviewed could articulate the procedure for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was audited on an ongoing basis to ensure it was appropriate and accurate. There was no evidence that analysis had been completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission. Information booklets were available on each unit, and these reflected the nature of the care and services provided in the different units. The booklets also outlined the housekeeping arrangements, complaints procedures, and visiting times and arrangements. Information was also provided on the multi-disciplinary team (MDT).

Residents received written and verbal information about their diagnosis, unless the provision of such information might be detrimental to their health and well-being. They had access to information on the likely adverse effects of treatments. Verbal information on medication was provided in an easily understood manner. However, medication information sheets were available only on request, except in Unit 4, where leaflets and information on mental health were readily available.
Medication-information leaflets were in a format appropriate to residents’ needs, and information was derived from evidence-based sources and appropriately reviewed and approved prior to use. All information provided to residents was documented in clinical notes. Where necessary, residents had access to interpretation and translation services.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: Quarterly audits were undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had not been completed to improve processes relating to resident privacy.

Evidence of Implementation: Residents were addressed by their preferred names. Staff spoke to residents in a kind and respectful way and were discreet when discussing residents’ condition or treatment needs. Staff sought permission before entering residents’ rooms. Staff dress was not always appropriate to residents’ needs. For example, one agency staff member was observed wearing a long white coat.

Not all bathrooms, showers, toilets, and single bedrooms had locks with an override facility, and not all single rooms were lockable from the inside. In shared rooms, privacy was not always assured. On Unit 3, screening curtains did not fully surround the beds. A number of curtains throughout the approved centre required maintenance. Observation panels in shared rooms/wards were not appropriately screened.

Resident names and other identifiable information were displayed in the dining room in Unit 8. In Unit 3, the full names of residents and of allocated key workers were displayed in an area accessible to visitors. Residents were not always facilitated in making private phone calls. Some residents had their own phones, and residents on all units, apart from Unit 5, has access to portable phones. Residents on Unit 5 had to use the staff office to make calls, and staff admitted to “keeping an eye” on calls in the office.

When an acute bed was required for a new admission, residents from Unit 4 were moved to Unit 8, which compromised their privacy.

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

a) A number of screening curtains were broken and some did not fully extend around the beds in shared rooms.

b) Shared rooms/wards in some areas were not appropriately screened.
c) Residents were not consistently able to make phone calls in private.

d) Identifiable resident information was displayed in communal areas on units 3 and 8.

e) Residents from Unit 4 were moved to Unit 8 when an acute bed was required, and this compromised their privacy.
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 written policy in relation to its premises, which was last reviewed in November 2015. It included requirements of the Judgement Support Framework, with the following exceptions:

- Details of the premises maintenance programme.
- The process for identifying hazards and ligature points in the premises.

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

Monitoring: The approved centre had completed a hygiene audit. Analysis was ongoing to identify opportunities for improving the premises, including renovation to bring units up to basic building standards and improve the environment for residents. No ligature audit had been completed since 2010.

Evidence of Implementation: The approved centre provided residents with access to personal space and to appropriately sized communal rooms on all units. There was sufficient indoor and outdoor space in which residents could move about. All communal and bedroom areas were adequately heated and appropriately lit.
The approved centre did not provide accommodation for each resident to ensure comfort and privacy and to meet their assessed needs. Not all rooms were well ventilated, and there was a malodorous smell in a number of areas: one of the female wards in Unit 2, toilets areas on Unit 5, a large room on Unit 5, and one room on Unit 3. The signage and sensory aids were not always appropriate to support residents’ orientation needs. All signs required good literacy skills to interpret, and only some of the toilets had male/female signs on the doors.

Hazards had not been minimised throughout the approved centre. There were ligature anchor points observed on all five wards. A ligature audit had not been completed since 2010 and did not reflect the current status of the building.

There was no maintenance schedule for addressing issues that had been identified and reported. For example, on the second day of the inspection, a single room on Unit 8 was noted to have two screws sticking out of a wardrobe door where the handle had fallen off. The issue, which was said to have been ongoing for at least five days, had been reported. It was addressed by the third day of the inspection. One door had a broken sign with sharp edges. Ligatures had not been minimised, and ligature points were identified on all units.

The units in the approved centre were not in a good state of repair, either internally or externally. Units 2 and 4 needed painting and new flooring but were clean; Units 3 and 5 were in an inadequate state of repair. Although a cleaning schedule was in place and current national infection control guidelines were followed, the approved centre was not clean, hygienic, and free from offensive odours. Units 3 and 5 were dirty, toilets were stained, pedestals were rusty, and faeces was observed on the assistance bars in a toilet on Unit 5.

There were sufficient toilet and bathroom facilities for residents in the approved centre, but signage did not always identify toilets, including wheelchair accessible facilities. There were designated sluice, cleaning, and laundry rooms. Residents’ bedrooms were appropriately sized to address resident needs, and dedicated examination rooms were available.

Furnishings throughout the approved centre did not always support residents’ independence and comfort. New furnishings had been installed in Unit 8, but elsewhere in the approved centre couches and chairs were worn and some chairs had cigarette burns.

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

- a) The premises were not clean and maintained in good structural and decorative condition, 22(1)(a).
- b) The premises were not adequately ventilated, 22(1)(b).
- c) A programme of routine maintenance and decoration was not implemented, 22(1)(c).
- d) Furnishings were not always adequate and suitable for the number and mix of residents, 22(2).
e) Hazards, including ligature points, had not been minimised, meaning that the physical structure and overall environment were not maintained with due regard to the needs of residents and patients and 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 policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in November 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: All nursing, medical, and pharmacy staff had signed a log indicating that they had read and understood the policy. Nursing and pharmacy staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff on all units had access to comprehensive information on medications and their management. Pharmacists had trained clinical staff on medication management and error reporting, and this was documented.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policies and procedures and with the relevant legislation and guidelines. Medication incidents, errors, and near misses were recorded via the National Incident Management System. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: An MPAR was maintained for each resident, and 41 of these were inspected. In each, at least two resident-specific identifiers were used when medication was being administered. The Medical Council Registration Numbers of medical practitioners prescribing medication to residents were recorded, and the signature of the prescriber accompanied each entry. The allergy section of the MPAR was completed in all cases. The names of medications were written in full, but generic medication names were not used in nine MPARs examined.

A new MPAR format was being piloted at the time of the inspection, and it contained dedicated space to list routine, once-off, and as-required medications. The frequency, dosage, and administration route for the medication were recorded and all medications administered to the resident were listed. A record was maintained of medications refused by the resident. The discontinuation date for each medication was not recorded in two MPARs.

Residents’ medication was reviewed at least six-monthly, and where there was an alteration in the medication order, the prescription was rewritten by the medical practitioner. All drugs were appropriately administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members against the delivery form and the details were entered into a controlled drug register.
The pharmacist documented specific advice relating to medications on MPARs, where appropriate, and worked with nursing staff to check expiration dates and return expired or unused stock to the pharmacy. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications.

Where a resident’s medication was withheld or where a resident refused medication, this was documented in the MPAR and the clinical file. A direction to crush medication was only accepted from the resident’s medical practitioner.

Medication arriving from the pharmacist was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a daily log of fridge temperatures was maintained. Medication storage areas were kept clean and tidy, and food and drink were not stored in these areas.

The medication trolley was locked and secure, and scheduled controlled drugs were secured separately. Medication dispensed to residents was stored securely. An inventory of medications was completed regularly by the nursing staff in conjunction with the pharmacist.

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 evidence of implementation pillar.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, which was last reviewed in November 2015, and a safety statement, dated February 2017. There was also a separate fire safety procedure, register, and plan. The policies included all of the requirements of the Judgement Support Framework.

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

Monitoring: The health and safety policies were monitored pursuant to Regulation 29: Operational Policies and Procedures.

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

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

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

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

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to staffing, which was last reviewed in November 2015. It stated that the HSE recruitment policy applied in the approved centre, and it covered roles and responsibilities in relation to the recruitment, selection, vetting, and appointment of staff. It also outlined the job description requirements, the organisational structure of the approved centre, the use of agency staff, and staff access to relevant training, including orientation and induction training for new staff.

The policy did not provide details of the following:

- Staff planning requirements.
- Staff rosters and their communication to staff.
- Staff performance and evaluation requirements.
- The reassignment of staff.
- The transfer of responsibility between staff members.
- The frequency of staff training.
- The required qualifications of training personnel.
- The evaluation of training programmes.

The policy appeared to contradict itself by referencing both the HSE recruitment policy and the approved centre’s recruitment policy.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.
Monitoring: The staff training plan was reviewed annually to ensure its implementation and effectiveness. The number of skill mix of staff were reviewed against the levels recorded in the approved centre’s registration. There was documented evidence that analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability, but it did not accurately represent the governance structures and processes of the approved centre.

Staff were appointed via the National Recruitment Service, with the exception of some nursing posts that were recruited directly by the CHO 4 Mental Health Service. All staff were vetted in accordance with the approved centre’s policy and procedures.

There was a planned and actual staff rota. The number and skill mix of staffing met resident needs, staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. There was an up-to-date staffing plan, all staff had individual training plans that were updated annually, and all training was documented. Staff training records indicated that no staff discipline was fully compliant in relation to required training in fire safety, Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act (MHA) 2001. There was, however, an active training programme in place and most nursing staff had completed training.

Staff had received training in Children First. Staff were trained in accordance with the assessed needs of the residents, and additional training had been delivered on manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults. There was evidence that opportunities for further education were made available to staff and that in-service training was delivered in an appropriate setting by suitably trained and competent individuals.

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>
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<tbody>
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<td>Unit 5</td>
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<td>RPN</td>
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<td>2</td>
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<table>
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<th>Ward or Unit</th>
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<th>Day</th>
<th>Night</th>
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</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)
The approved centre was not compliant with this regulation because not all staff had up-to-date training in fire safety, BLS, the management of aggression and violence, and the MHA 2001, 26(4) and (5).

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
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<td></td>
<td>RPN</td>
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<td>3</td>
</tr>
<tr>
<td></td>
<td>RPN specials (during inspection)</td>
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<td>3</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.8</td>
<td>0</td>
</tr>
</tbody>
</table>
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in November 2015. It included requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

It did not include a process for making a retrospective entry in residents’ records.

Training and Education: There was no evidence to indicate that all clinical staff and other relevant staff had read and understood the policy. Staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policy. All clinical staff were trained in best-practice record keeping as part of their general professional training.

Monitoring: There was no documented audit of resident records to ensure their completeness, accuracy, and ease of retrieval. No analysis had been conducted to identify opportunities for improving processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were stored in a locked filing cabinet in a locked room on each unit, and all residents had a clinical file. Files were up to date, were reflective of the residents’ current status and the care and treatment being provided, and were maintained using a resident-specific identifier (a unique medical record number). Records could only be accessed by authorised staff, who had...
sole authority to make entries in them. Resident records contained factual, consistent entries written legibly in black ink, dated, and accompanied by a signature.

Not all records were maintained in good order. It was noted that numerous files were not arranged in a logical sequence and contained loose pages, which did not facilitate retrieval of information. The time at which entries were made was not recorded in any of the records.

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

The approved centre was not compliant with this regulation because not all records were maintained in good order, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

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

**Monitoring:** An annual audit was undertaken to determine compliance with review time frames. Analysis had been completed by the Policy and Procedure Group to identify opportunities for improving the process of developing and reviewing policies.

**Evidence of Implementation:** Operating policies and procedures were developed with input from clinical, managerial, and multi-disciplinary team staff. Policies were drawn up by the North Cork Mental Health Service Policy, Protocol and Guidelines (PPG) committee, and draft guidelines were developed in consultation with a representative from a service user group such as the Irish Advocacy Network. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines, and they were approved by the local management team.

All policies required by the regulations were reviewed within the required three-year time frame. Up-to-date versions of all policies and procedures were maintained in hard-copy or electronic versions and could be accessed by relevant staff during working hours.

Obsolete versions of policies and procedures were archived and removed from circulation. Policies and procedures were presented in a standardised format that included the title, reference and version number, details of the document owner, date of implementation, and details of approvers and reviewers. The total number of pages in the policy was not included in all documents.

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 evidence of implementation pillar.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of Mental Health Tribunals, which was last reviewed in November 2015. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were familiar with the policy and its implications for staff and the service.

Monitoring: There was no documentary evidence that analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: To support the tribunal process, the approved centre provided a private tribunal room, which was of adequate size. Suitable resources were in place to support the Mental Health Tribunal process. Nursing staff assisted and supported residents to attend and participate, where necessary.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in November 2015. It also used the HSE’s Your Service, Your Say complaints procedure. The policy included all the requirements of the Judgement Support Framework.

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

Monitoring: There was no documented evidence that audits of the complaints log had been completed. Complaints data had not been audited for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. Complaints received by phone, in writing, or through the suggestion box were logged. Ways in which residents and their representatives could lodge a complaint were detailed in information leaflets and posters. The approved centre’s management of complaints was well publicised and accessible.

All complaints were documented, investigated promptly, and handled with sensitivity. The complaints officer opened a file for each new complaint, which included details of the complaint, the subsequent investigation, and the outcome.
Minor complaints were logged and dealt with appropriately. The quality of service, care, and treatment of a resident was not adversely affected by reason of a complaint being made. Details of complaints, investigations, and outcomes were recorded and kept separately from the resident's individual care plan.

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 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 series of policies in relation to risk management and incident management procedures, including a risk management procedures policy dated March 2017. There were policies for responding to medical emergencies (March 2017), managing non-clinical risk (March 2017), prevention and management of aggression and violence (March 2017), managing a situation in which a resident was missing/absent (February 2014), handling serious untoward incidents (February 2014), managing disturbed/aggressive behaviour (November 2016), incident reporting (February 2017), suicide prevention (February 2014), and safety (2016). The HSE’s national policy on the protection of vulnerable adults was referenced in the risk management procedures policy, and the protection of children was referenced in the admission of children policy and the requirement for all staff to attend Children First training.

Together, the policies covered all the requirements of the Judgement Support Framework, including processes for the following:

- The identification, assessment, treatment, reporting, and monitoring of risks.
- Rating identified risks.
- Controlling resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents.
- Responding to emergencies.
Training and Education: Relevant staff had received training in risk management processes, including organisational risk, incident reporting, and health and safety. All staff had signed a log indicating that they had read and understood the risk management policy, and staff interviewed were able to articulate the risk management processes, as set out in the policies. All training was documented.

Monitoring: The risk register was up to date, but there was no evidence that it had been audited at least quarterly to determine compliance with the approved centre’s risk management policies. All incidents were recorded and risk-rated using the National Incident Management System (NIMS).

Evidence of Implementation: The approved centre had a designated risk advisor, who was known to staff. Responsibilities were allocated at management level to address risk management. Clinical and corporate risks were identified, assessed, controls identified, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, controls identified, reported, monitored, and documented in local risk registers on each unit. However, the approved centre’s own risk management procedures as outlined in their risk assessment of 01 February 2017 were not fully implemented in relation to ligature anchor points. The last ligature audit had been completed in 2010, and it no longer reflected the current status of the approved centre, where ligature anchor points were observed during the inspection.

Risk assessments of residents were completed prior to and during episodes of physical restraint and prior to transfer and discharge. At admission, residents were clinically risk assessed using the shortened Sainsbury Risk Assessment Tool. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of individual risk management processes, and residents and/or their representatives were involved in the process. The requirements for protecting children and vulnerable adults in the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated using a NIMS form. Clinical incidents were reviewed by MDT members, as evidenced by follow-up reports on two incidents. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. The approved centre had an emergency plan and policy that included evacuation procedures. Emergency incidents were escalated to the CH0 4 manager for mental health services and to the HSE’s Emergency Executive Committee.

The approved centre was non-compliant with Regulation 32 because despite having comprehensive risk management policies and procedures in place, the approved centre did not fully implement these in relation to ligature anchor points. The approved centre’s risk register required ligature anchor point audits to be completed and the most recent audit had been completed in 2010 and did not reflect the current status of the premises 32(1).
<table>
<thead>
<tr>
<th>Regulation 33: Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.</td>
</tr>
<tr>
<td><strong>INSPECTION FINDINGS</strong></td>
</tr>
<tr>
<td>The approved centre’s insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered under the auspices of the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.</td>
</tr>
<tr>
<td>The approved centre was compliant with this regulation.</td>
</tr>
</tbody>
</table>
**Regulation 34: Certificate of Registration**

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

**INSPECTION FINDINGS**

The approved centre had an up-to-date certificate of registration, which was displayed in the main reception area. The conditions attached to the certificate were not displayed.

The approved centre was not compliant with this regulation because the conditions attached to the certificate of registration were not on display.
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

Given that Electro-Convulsive Therapy was not used in the approved centre, this rule was not applicable.
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Given that seclusion was not used in the approved centre, this rule was not applicable.
Section 69: The Use 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

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

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

The files of three involuntary patients who had been in the approved centre for more than three months and who were in continued receipt of medication were inspected. A Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed for each patient. Copies of these were retained in the clinical files. Each Form 17 included details of the following:

- Confirmation of an assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medication.
- Discussion with the patient in terms of the nature and purpose and effects of the medication.
- Supports provided to the patient in terms of the discussion and their decision-making process.
- Views expressed by the patient.
- Authorisation of medication by a second consultant psychiatrist.
In two cases the forms did not specify the medication prescribed to the patients.

The approved centre was not compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because the specific medication prescribed to the patients was not recorded on Form 17.
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 three up-to-date written policies in relation to the use of physical restraint: a physical restraint policy, a physical restraint of a child policy, and a policy on the prevention and management of aggression and violence. The policies outlined responsibilities in relation to initiating and overseeing restraint processes. They documented procedures for the provision of information to residents undergoing restraint and provided details of staff training requirements, including the frequency of training, those who should receive training, areas to be addressed during training, and alternatives to the use of physical restraint.

**Training and Education:** Staff on each unit had signed a log indicating that they had read and understood the policies. A record of staff attendance at training on the use of physical restraint was maintained. Restraint was never used to ameliorate staff shortages.

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

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

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

In each case, the resident was informed of the reasons for the restraint, its likely duration, and the circumstances in which physical restraint would be discontinued.

The approved centre was compliant with this code of practice.
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 no children had been admitted to the approved centre since the 2016 inspection, this code of practice was not applicable.

**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

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

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

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

Evidence of Implementation: The approved centre used the National Incident Management System for reporting incidents, and the standardised incident report form was available to the inspection team. A six-monthly summary of all incidents was sent to the MHC. The death of a resident of the approved centre who had been transferred to another facility for treatment was not notified to the MHC within the required 48-hour time frame.

The approved centre was not compliant with this code of practice because the death of one resident was not notified to the MHC within the required 48-hour time frame, 2.1.
INSPECTION FINDINGS

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

- The roles and responsibilities of multi-disciplinary team members.
- The process for ensuring appropriate and relevant communication and liaison with external agencies.
- Procedures for the training of staff in working with people with an intellectual disability.

The policy did not reference the management of problem behaviours.

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

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

Evidence of Implementation: The files of three residents of the approved centre who were diagnosed with an intellectual disability were inspected. Two residents were accommodated in Unit 3 and did not have an appropriate individual care plan (ICP). Nursing care plans were available but not multi-disciplinary ICPs. The third resident was accommodated in Unit 5.

The clinical files indicated that the residents had received a comprehensive assessment that included an evaluation of performance capacities and difficulties; communication issues; medical, psychiatric, and psychosocial history; and social, interpersonal, and physical environment issues. Each resident was assigned a key worker. All three residents attended the Valley View resource centre, where they had opportunities to engage in meaningful activities.

The residents’ preferred ways of receiving and giving information were documented in the clinical files, as was their understanding of information.

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

- a) The policy on working with people with an intellectual disability did not reference the management of problem behaviours (5.3).
b) Two residents with an intellectual disability did not have an appropriate, multi-disciplinary ICP (8.1 and 8.3).
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

**INSPECTION FINDINGS**

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

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

INSPECTION FINDINGS

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

Admission: The admission policy was last reviewed in March 2017. It included all of the criteria of this code of practice, including processes relating to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. The policy contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams. There was a policy on confidentiality, privacy, and consent.

Transfer: The transfer policy, which was last reviewed in March 2017, detailed how a transfer was arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary, emergency, and overseas transfer, and it addressed the safety of residents and staff during a transfer.

Discharge: The approved centre had two discharge policies: a general policy and a policy on discharge against medical advice. The general policy included procedures for discharging involuntary patients, homeless people, and elderly people. It referenced prescriptions and supply of medication on discharge and documented the roles and responsibilities of staff in relation to providing follow-up care. Details were included of when and how much follow-up contact residents should have, relapse prevention strategies, and a process for following up and managing missed appointments. The policy did not include a protocol for discharging people with an intellectual disability.

Training and Education: There was documentary evidence that staff had read and understood the policies.

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

Evidence of Implementation:

Under effective governance at 7.1 this code of practice requires compliance with Regulation 32 Risk Management procedures. The approved centre was non-compliant because it did not comply with Regulation 32: Risk Management Procedures.
Admission: Three clinical files were reviewed in relation to admission. These indicated that the approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). Residents were assessed at admission, and assessments and examinations were documented in the clinical files. In two of the files inspected, there was no evidence that a physical examination had been completed. There was evidence of family member/carer involvement in the admission process. Residents were admitted to the unit most appropriate to their needs.

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

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical file of one resident who was transferred for specialised treatment to a general hospital was examined. The decision to transfer was made by the RMP following a medical review. A pre-transfer assessment, including a risk assessment, was undertaken. The resident’s consent to the transfer was documented in the nursing notes, and appropriate MDT involvement was recorded. Medical and nursing records indicated that a transfer letter was prepared and accompanied the resident to the emergency department. No copy of the letter was retained in the clinical file, however.

Discharge: The files of two recently discharged residents were inspected. In each case, the decision to discharge was taken by the RMP. Both files evidenced good discharge planning, with family consultation, follow-up planning, and appropriate MDT input. Discharge plans were in place as part of the residents’ individual care plans.

Documented discharge meetings were held in both cases. Full medical reviews were completed in advance of discharge, which was coordinated by the relevant key workers. Discharge summaries were sent to the relevant primary care teams within the required time frames. These included details of diagnosis, prognosis, medication, outstanding health or social issues, and follow-up arrangements. There was evidence of family/carer/advocate involvement in the discharge process.

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

a) It was not compliant with Regulation 32: Risk Management Procedures, 7.1.

b) The discharge policy did not include a protocol for the discharge of people with an intellectual disability, 4.16.

c) There was no evidence that an audit had been completed on the implementation of and adherence to the admission policy, 4.19.

d) In two files examined, there was no evidence that residents had a physical examination at admission, 15.3.

e) The admission process was non-compliant under Regulation 8: Residents’ Personal Property and Possessions, 23.1.1.
f) The admission process was non-compliant under Regulation 15: Individual Care Plan, 17.1.
g) The admission process was non-compliant under Regulation 27: Maintenance of Records, 22.6.
h) A copy of the referral letter that accompanied a resident who was transferred to another health care facility was not retained in the clinical file, 31.2.
### Appendix 1 – Corrective and Preventative Action Plans

#### Regulation 8: Residents’ Personal Property and Possessions


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
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</tbody>
</table>

#### 1. Units 3 and 8 did not maintain property logs, 8(3).

- **Reoccurring from 2016**
- **Corrective Action(s):**
  - Property logs are now maintained in both units. All staff informed of same.
  - Post-Holder(s) responsible: N/a.
- **Preventative Action(s):**
  - CNM II will monitor the completion of the patient property log on a weekly basis.
  - Post-Holder(s) responsible: N/a.

- **Property logs are now maintained in both units.**
- **This objective has been achieved.**
- **Completed.**

#### 2. There was a lack of appropriate, individual storage facilities to support residents to retain control of personal property and possessions, 8(5).

- **New**
- **Corrective Action(s):**
  - ADONS will organise an audit of their respective units.
  - Post-Holder(s) responsible: For Unit 8: D. Nolan (ADON); For Unit 3: T. McSweeney (ADON);
- **Preventative Action(s):**
  - Inspection.

- **Inspection of each unit**
- **This is both achievable and realistic. No barriers to implementation.**
- **To be completed by 30th September 2017.**

---

1 Area of non-compliance reoccurring from 2016
2 Area of non-compliance new in 2017
New wardrobes have since been purchased for residents in Unit 3.

### Regulation 14: Care of the Dying (and Code of Practice: Notification of Deaths and Incident Reporting)

**Report reference: Page 33 and 75**

<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>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>3. The death of one resident was not notified to the MHC within the required time frame.</strong></td>
<td>New</td>
<td>Corrective Action(s): A memo was sent by the Mental Health Act Administrator on 26th July 2017 to all Consultants and relevant medical personnel to ensure this regulation will be adhered to going forward. Please see attached correspondence</td>
<td>Memo sent reminding of the 48 hour deadline.</td>
<td>This is objective has been achieved.</td>
</tr>
<tr>
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<td>Preventative Action(s) All Consultants and relevant personnel have been informed of the importance of adhering to the Code of Practice: Notification of Deaths and Incident Reporting.</td>
<td>Code of Practice: Notification of Deaths and Incident Reporting will be available for inspection.</td>
<td>This is objective has been achieved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: N/a.</td>
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</tbody>
</table>
### Regulation 15: Individual Care Plan

*Report reference: Page 34 – 35*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<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>4. Not all ICPs contained a specified set of goals.</td>
<td>Reoccurring from 2016</td>
<td>Corrective Action(s): Further training is to be rolled out to all teams by the Practice Development Co-ordinator in conjunction with ADON with responsibility for Regulations and Compliance. Quarterly audits will be conducted. Post-Holder(s) responsible: D. Nolan (ADON); to liaise with Practice Development Co-ordinator.</td>
<td>Quarterly Audit of the ICP.</td>
<td>This is both achievable and realistic. Training scheduled for 31/08/17.</td>
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<tr>
<td></td>
<td></td>
<td>Preventative Action(s): All MDT Staff will be made aware of the need to ensure that ICP’s contain a specific set of goals. Post-Holder(s) responsible: Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager).</td>
<td>Quarterly Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>5. Not all ICPs clearly identified necessary resources to meet identified needs.</td>
<td>Reoccurring from 2016</td>
<td>Corrective Action(s): Further training is to be rolled out to all teams by the Practice Development Co-ordinator in conjunction with ADON with responsibility for Regulations and Compliance. Post-Holder(s) responsible: D. Nolan (ADON); to liaise with Practice Development Co-ordinator.</td>
<td>Quarterly Audit of the ICP.</td>
<td>This is both achievable and realistic. No barriers to implementation.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<tr>
<td><strong>Preventative Action(s):</strong> Further training is to be rolled out and included in training provided. Post-Holder(s) responsible: D. Nolan (ADON); to liaise with Practice Development Co-ordinator.</td>
<td>Quarterly Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
<td>End of 3rd quarter, 2017.</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Holder(s) responsible:</strong> D. Nolan (ADON);</td>
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<tr>
<td><strong>Quarterly Audit of the ICP.</strong></td>
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<tr>
<td><strong>This is both achievable and realistic.</strong></td>
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<tr>
<td><strong>End of 3rd quarter, 2017.</strong></td>
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</tbody>
</table>

6. ICPs were not consistently completed in consultation with the resident. New

**Corrective Action(s):**
This area of non-compliance will be incorporated into training provided to teams.
Post-Holder(s) responsible:
Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager).

Preventative Action(s):
It is planned that information sessions about Care Plans will be facilitated for all residents in all units. These will include components such as; what is a CP, making it work for you etc.
Post-Holder(s) responsible:
Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager).

Quarterly Audit of the ICP.

Quarterly Audit of the ICP.

This is both achievable and realistic.

End of 3rd quarter, 2017.

<table>
<thead>
<tr>
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<th>Corrective Action(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is planned that information sessions about Care Plans will be facilitated for all residents in all units. These will include components such as; what is a CP, making it work for you etc.</td>
<td>Further personnel to be allocated to the MDT’s which will ensure full involvement of the MDT (e.g. Senior Occupational Therapist to commence 23/08/17).</td>
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<tr>
<td>Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager).</td>
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**Quarterly Audit of the ICP.**

Quarterly Audit of the ICP.

| This is both achievable and realistic. | This is both achievable and realistic. | This is both achievable and realistic. | This is both achievable and realistic. |
| | | | End of 3rd quarter, 2017. |
| | | | End of 3rd quarter, 2017. |
| | | | End of 3rd quarter, 2017. |

7. Not all ICPs were developed by the MDT. Reoccurring from 2016

**Corrective Action(s):**
Further personnel to be allocated to the MDT’s which will ensure full involvement of the MDT (e.g. Senior Occupational Therapist to commence 23/08/17). Post-Holder(s) responsible:

Quarterly Audit of the ICP.

Quarterly Audit of the ICP.

This is both achievable and realistic.

End of 3rd quarter, 2017.
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<th>Area(s) of non-compliance</th>
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<tr>
<td></td>
<td>Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager).</td>
<td>Preventative Action(s): Further personnel to be allocated to the MDT’s which will ensure full involvement of the MDT. (e.g. Senior Occupational Therapist to commence 23/08/17). Post-Holder(s) responsible: Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager). Pre</td>
<td>Quarterly Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
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<tr>
<td>8. Not all ICPs specified the treatment and care required.</td>
<td>Corrective Action(s): The Care Plan template is being standardized and will be used by all members of the MDT. Post-Holder(s) responsible: Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager). Preventative Action(s): Once the Care Plan template is updated all relevant staff &amp; members of the MDT will be advised of the new template in implementation. Post-Holder(s) responsible: Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager). Pre</td>
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<td>This is both achievable and realistic.</td>
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Regulation 19: General Health

<table>
<thead>
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<tr>
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<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>9. Not all residents’ general health needs were assessed at least every six months.</td>
<td>New</td>
<td>Corrective action(s): Memo was sent by Mental Health Administrator on 27th July to all Consultants and Clinicians advising re. requirement to have 6 monthly general health reviews carried out and same recorded. Physical Examination record logs have been placed in all units. All residents’ general health needs have been assessed within the last six months. Post-Holder(s) responsible: N/a.</td>
<td>Twice yearly audits to be carried out.</td>
<td>This objective has been achieved.</td>
</tr>
</tbody>
</table>

Preventative Action(s):
Physical Examination record logs have been placed in all units. Please see attachments.
Post-Holder(s) responsible: N/a.

Twice yearly audits to be carried out. This objective has been achieved. Completed.
Memo sent and Logs placed in units.
### Regulation 21: Privacy

Report reference: Page 43 – 44

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
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<tr>
<td>Taken from the inspection report</td>
<td></td>
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</tr>
<tr>
<td><strong>10.</strong> A number of screening curtains were broken and some did not fully extend around the beds in shared rooms.</td>
<td>New</td>
<td>Screening curtains have since been replaced ensuring privacy.</td>
<td>Completed.</td>
<td>Completed.</td>
</tr>
<tr>
<td><strong>11.</strong> Shared rooms/wards in some areas were not appropriately screened.</td>
<td>New</td>
<td>New screens provided which let light in but maintain privacy.</td>
<td>Completed.</td>
<td>Completed.</td>
</tr>
<tr>
<td><strong>12.</strong> Residents were not consistently able to make phone calls in private.</td>
<td>Reoccurring from 2016</td>
<td>Residents have access to portable phones.</td>
<td>Completed.</td>
<td>Completed.</td>
</tr>
<tr>
<td><strong>13.</strong> Identifiable resident information was displayed in communal areas on units 3 and 8.</td>
<td>New</td>
<td>Corrective action(s): T Card system to be implemented. This will provide a system where the residents’ names will be displayed in an MDT office which will not be visible to the general public. Where identifiable resident information was displayed in a communal area in unit 8 floor 2, I can confirm that this practice has ceased.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>System to be implemented asap. Will be reviewed at next monthly management meeting.</td>
<td>This is both achievable and realistic.</td>
<td>End of September 2017.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Achievable / Realistic</td>
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<tr>
<td></td>
<td>Preventative Action(s): T Card system to be implemented. This will provide a system where the residents’ names will be displayed in an MDT office which will not be visible to the general public. Where identifiable resident information was displayed in a communal area in unit 8 floor 2, I can confirm. Post-Holder(s) responsible: D. Nolan (Assistant Director of Nursing). For Unit 3: T McSweeney, (Assistant Director of Nursing). System to be implemented asap. Will be reviewed at next monthly management meeting.</td>
<td>This is both achievable and realistic. No barriers</td>
<td>End of September 2017.</td>
<td></td>
</tr>
<tr>
<td>14. Residents from Unit 4 were moved to Unit 8 when an acute bed was required, and this compromised their privacy.</td>
<td>Corrective action(s): Prior to any resident being requested to transfer to another ward overnight, full risk assessment on the patient transferring and to be undertaken. Post-holder(s) responsible: Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); S. O’Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager). Ongoing review of bed requirements and measures which impact on same in St Stephen’s campus and associated community services underway.</td>
<td>This is both achievable and realistic. No barriers</td>
<td>By mid-2018.</td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<tr>
<td></td>
<td>Preventative Action(s): Monitoring in relation to this issue is ongoing. Area Administrator is liaising / working with Clinical Director to ensure this practice ceases as soon as possible. Figures submitted to MHC in March 2017 in relation to sleeping out were 8. 8 residents slept out in April. There were no residents sleeping out in May or June 2017. Post-holder(s) responsible: Dr H. Doyle, (Clinical Director); N. Kelly (Area Director of Nursing); M. Cummins (Area Administrator); S. O’ Flynn (Occupational Therapy Manager); E. Lonergan (Principal Psychology Manager); D. Hughes (Social Work Manager).</td>
<td>Ongoing review, monitoring and data analysis of same.</td>
<td>Working towards the objective of no sleeping out of residents.</td>
<td>By mid-2018.</td>
</tr>
</tbody>
</table>
Regulation 22: Premises

Report reference: Page 45 - 46

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring or New area of non-compliance</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>15. The premises were not clean and maintained in good structural and decorative condition.</td>
<td>Reoccurring from 2016 - Monitored as per condition³</td>
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<tr>
<td>16. The premises were not adequately ventilated.</td>
<td>Reoccurring from 2016</td>
<td></td>
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<tr>
<td>17. A programme of routine maintenance and decoration was not implemented.</td>
<td>Reoccurring from 2016</td>
<td></td>
<td></td>
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<tr>
<td>18. Furnishings were not always adequate and suitable for the number and mix of residents.</td>
<td>New</td>
<td></td>
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</tr>
<tr>
<td>19. Hazards, including ligature points, had not been minimised, meaning that the physical structure and overall environment were not maintained with due regard to the needs of residents and patients and the safety and well-being of residents, staff, and visitors.</td>
<td>Reoccurring from 2016</td>
<td></td>
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</tr>
</tbody>
</table>

³ To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Area(s) of non-compliance

<table>
<thead>
<tr>
<th>Taken from the inspection report</th>
<th>Reoccurring or New area of non-compliance</th>
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<tbody>
<tr>
<td>20. Not all staff had up-to-date training in fire safety, BLS, the management of aggression and violence, and the MHA 2001.</td>
<td>Reoccurring from 2015 - Monitored as per condition&lt;sup&gt;4&lt;/sup&gt;</td>
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<sup>4</sup> To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all health care professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.
**Regulation 27: Maintenance of Records**

*Report reference: Page 54 – 55*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>21. Not all records were maintained in good order.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): The policy in relation to the maintenance of records has been updated to include making retrospective entries, this policy is being prepared for sign off. ADON will link with members of Audit group around carrying out regular audit of residents records. ADONS to advise/train staff re. maintaining good records e.g. need for logical order, secure pages and need to record time of entry. Post-Holder(s) responsible: M. Cummins (Area Administrator).</td>
<td>Subject to 6 monthly audit.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): The policy in relation to the maintenance of records has been updated to include making retrospective entries, this policy is being prepared for sign off. ADON will link with members of Audit group around carrying out regular audit of residents records. ADONS to advise/train staff re. maintaining good records e.g. need for logical order, secure pages and need to record time of entry. Post-Holder(s) responsible: M. Cummins (Area Administrator)</td>
<td>Subject to 6 monthly audit.</td>
<td>This is both achievable and realistic.</td>
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## Area(s) of non-compliance

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</table>

### 22. Despite having comprehensive risk management policies and procedures in place, the approved centre did not fully implement these in relation to ligature anchor points. The approved centre’s risk register required ligature anchor point audits to be completed and the most recent audit had been completed in 2010 and did not reflect the current status of the premises.

<table>
<thead>
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<tr>
<td>Reoccurring since 2016 - Monitored as per condition⁵</td>
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</tbody>
</table>

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⁵ To ensure a comprehensive risk management policy is implemented in the approved centre in adherence to Regulation 32(1) and (2), the approved centre shall submit a copy of their risk register to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Regulation 34: Certificate of Registration

**Report reference:** Page 64

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>23. The conditions attached to the certificate of registration were not on display.</td>
<td>New</td>
<td>Corrective Action(s): These are now displayed side by side. Post-Holder(s) responsible: N/a.</td>
<td>The Certificate of Registration and Conditions attached are displayed side by side.</td>
<td>This objective has been achieved.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): These are now displayed side by side. Post-Holder(s) responsible: N/a.</td>
<td>The Certificate of Registration and Conditions attached are displayed side by side.</td>
<td>This objective has been achieved</td>
</tr>
</tbody>
</table>
## Part 4: Consent to Treatment

*Report reference: Page 70 – 71*

<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>24. The specific medication prescribed to the patients was not recorded on Form 17.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): Memo has been sent to all Consultants on 27.07.2017 advising re the requirement to enter the specific medication prescribed to the patients on Form 17. Post-Holder(s) responsible: N/a.</td>
<td>An email was issued to all Consultants on 27th July in relation to this.</td>
<td>This has been achieved.</td>
</tr>
</tbody>
</table>

Preventative Action(s): Memo has been sent to all Consultants on 27.07.2017 advising re the requirement to enter the specific medication prescribed to the patients on Form 17. Post-Holder(s) responsible: N/a.  
An email was issued to all Consultants on 27th July in relation to this.  
This has been achieved.  
Completed. Correspondence sent.
<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>25. The policy on working with people with an intellectual disability did not reference the management of problem behaviours.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): Policy has been reviewed and updated. See attached. Post-Holder(s) responsible: N/a.</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This objective has been achieved.</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Policy has been reviewed and updated. Staff informed of the updated policy. Post-Holder(s) responsible: N/a.</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This objective has been achieved.</td>
<td>Completed.</td>
</tr>
<tr>
<td>26. Two residents with an intellectual disability did not have an appropriate, multi-disciplinary ICP.</td>
<td>New</td>
<td>Corrective Action(s): The increase to the MDT will ensure full MDT input going forward. A Community Intellectual Disability Nurse has engaged with all nursing staff in Unit 3 and is due to advice on Care Planning for clients with an ID, from a Nursing perspective. Post-Holder(s) responsible: N/a.</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This objective has been achieved.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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</tr>
<tr>
<td></td>
<td>Preventative Action(s): The increase to the MDT will ensure full MDT input going forward. A Community Intellectual Disability Nurse has engaged with all nursing staff in Unit 3 and is due to advise on Care Planning for clients with an ID, from a Nursing perspective. Post-Holder(s) responsible: N/a.</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic. No barriers</td>
<td>Completed. Ongoing contact with the Community Mental Health Nurse for Intellectual Disability will be maintained.</td>
</tr>
</tbody>
</table>
## Code of Practice: Admission, Transfer and Discharge

Report reference: Page 79 – 81

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>27.</strong> The discharge policy did not include a protocol for the discharge of people with an intellectual disability.</td>
<td>New</td>
<td>Corrective Action(s): Policy has been reviewed, updated and signed off. Post-Holder(s) responsible: N/a.</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Policy has been reviewed, updated and signed off. All staff informed of the updated policy. Post-Holder(s) responsible: N/a.</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
</tr>
<tr>
<td><strong>28.</strong> There was no evidence that an audit had been completed on the implementation of and adherence to the admission policy.</td>
<td>New</td>
<td>Corrective Action(s): Audit of Code of Practice: Admission, Transfer and Discharge to be carried out. Post-Holder(s) responsible: D. Nolan (Assistant Director of Nursing)</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
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<td>Preventative Action(s): Audit of Code of Practice: Admission, Transfer and Discharge. Record logs have been placed in all units. Post-Holder(s) responsible: D. Nolan (Assistant Director of Nursing)</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
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<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<td>29. In two files examined, there was no evidence that residents had a physical examination at admission.</td>
<td>New</td>
<td>Corrective Action(s): Memo sent to all relevant Clinicians that physical examination must be conducted at admission. Post-Holder(s) responsible: Dr H. Doyle (Clinical Director) and Consultant Psychiatrists.</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
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<td>Preventative Action(s): Record logs have been placed in all units. (See attachments). Post-Holder(s) responsible: D. Nolan (Assistant Director of Nursing) For Unit 3: T. McSweeney (Assistant Director of Nursing)</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
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<td>30. A copy of the referral letter that accompanied a resident who was transferred to another health care facility was not retained in the clinical file.</td>
<td>New</td>
<td>Corrective Action(s): A Memo was issued on 27.07.2017 to Consultants &amp; CNM2’s in relation to this. Checklist to be drawn up to be included in residents files. Post-Holder(s) responsible: N/a</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
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<td>Preventative Action(s): CNM II to ensure checklist completed at time of transfer. Post-Holder(s) responsible: For Unit 4: C. Stack (CNM II); C. Barry (CNM II).</td>
<td>Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic. No barriers</td>
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