MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Acute Mental Health Unit, Cork University Hospital

ID Number: AC0096

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Mental Health Unit, Cork University Hospital
Wilton
Cork

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

Most Recent Registration Date:
4 February 2015

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

Inspection Team:
Martin McMenamin, Lead Inspector
Siobhan Dinan
Mary Connellan
Noeleen Byrne

Inspection Date:
13 – 16 February 2018

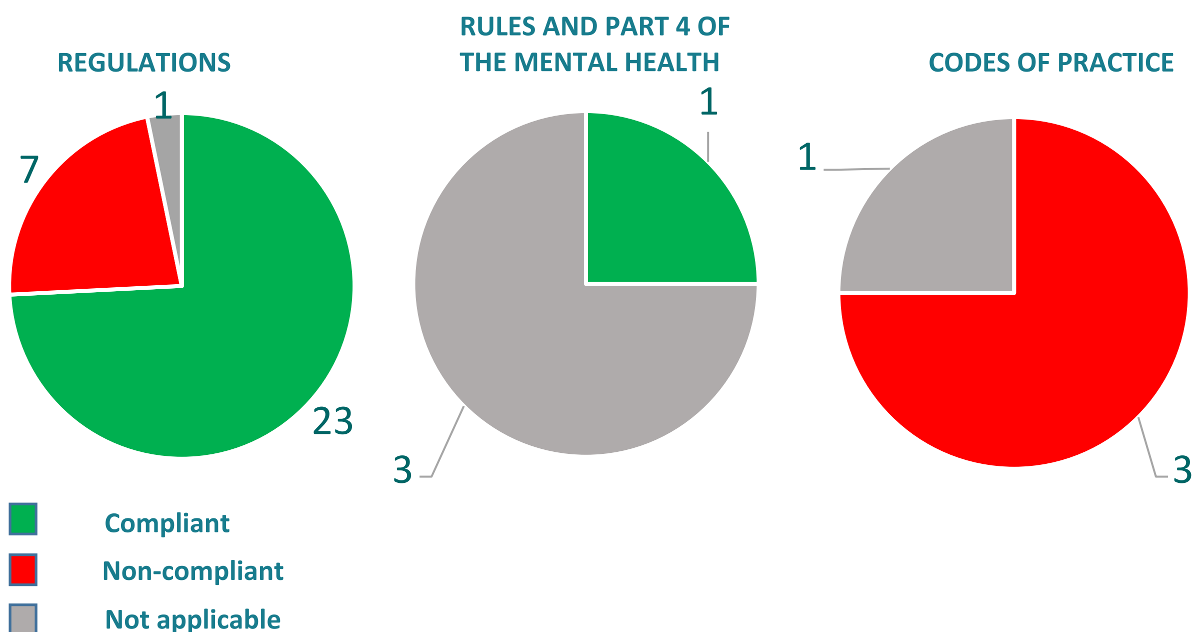
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
16 – 19 May 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
25 October 2018

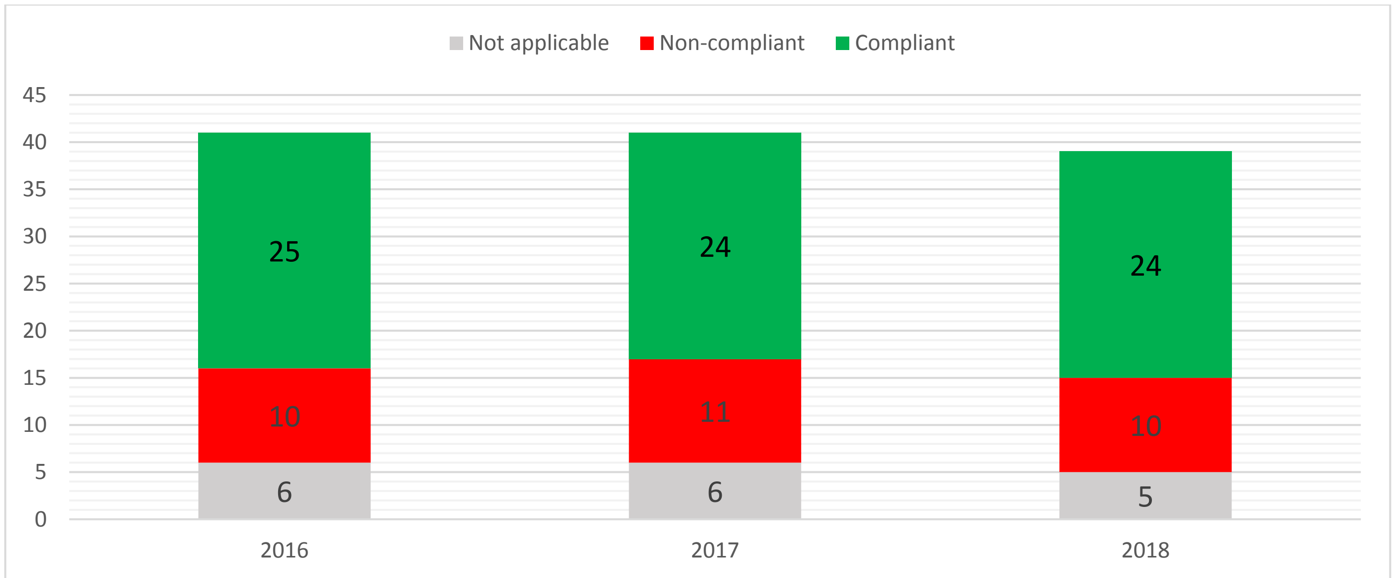
COMPLIANCE RATINGS 2018



RATINGS SUMMARY 2016 – 2018

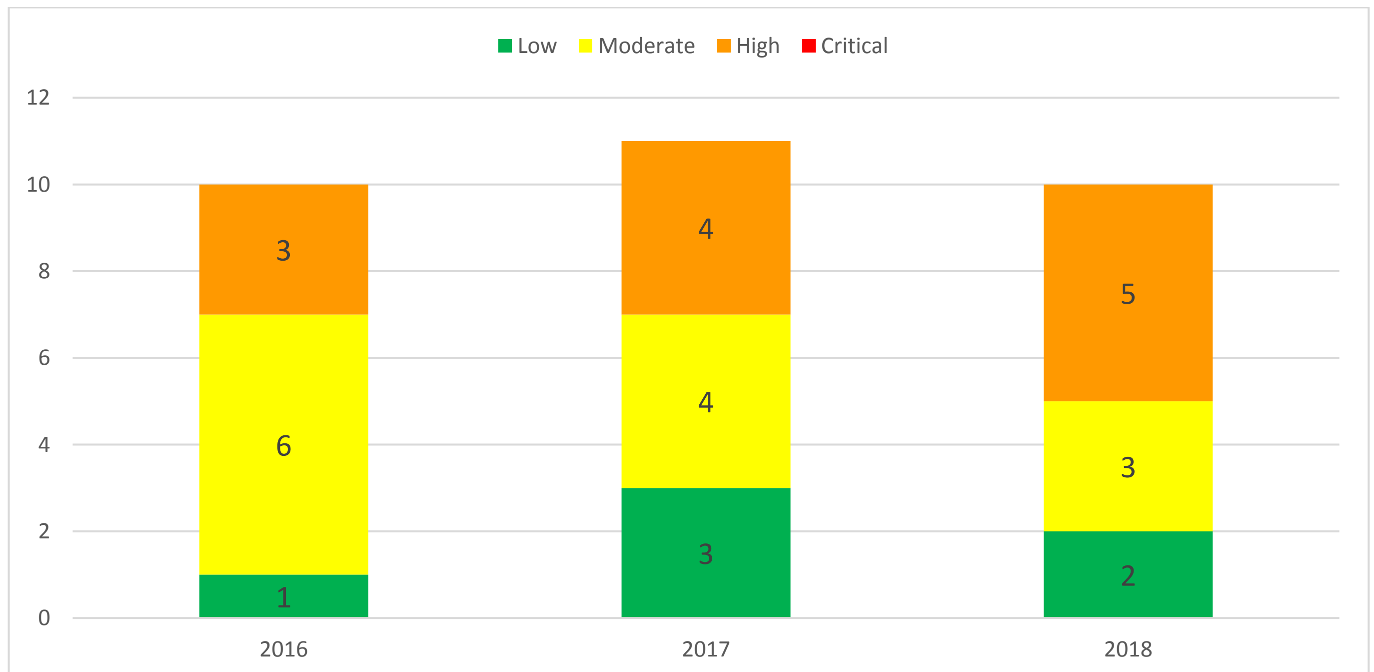
Compliance ratings across all 39 areas of inspection (2016, 2017) and 39 areas of inspection (2018) are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018



Contents

1.0 Introduction to the Inspection Process 4
2.0 Inspector of Mental Health Services – Summary of Findings 6
3.0 Quality Initiatives 9
4.0 Overview of the Approved Centre 10
4.1 Description of approved centre 10
4.2 Conditions to registration 10
4.3 Reporting on the National Clinical Guidelines 11
4.4 Governance 11
4.5 Use of restrictive practices....11
5.0 Compliance....13
5.1 Non-compliant areas on this inspection 13
5.2 Areas of compliance rated "excellent" on this inspection....13
5.3 Areas that were not applicable on this inspection 14
6.0 Service-user Experience 15
7.0 Feedback Meeting....16
8.0 Inspection Findings – Regulations....17
9.0 Inspection Findings – Rules 61
10.0 Inspection Findings – Mental Health Act 2001 62
11.0 Inspection Findings – Codes of Practice....65
Appendix 1: Corrective and Preventative Action Plan....70

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".

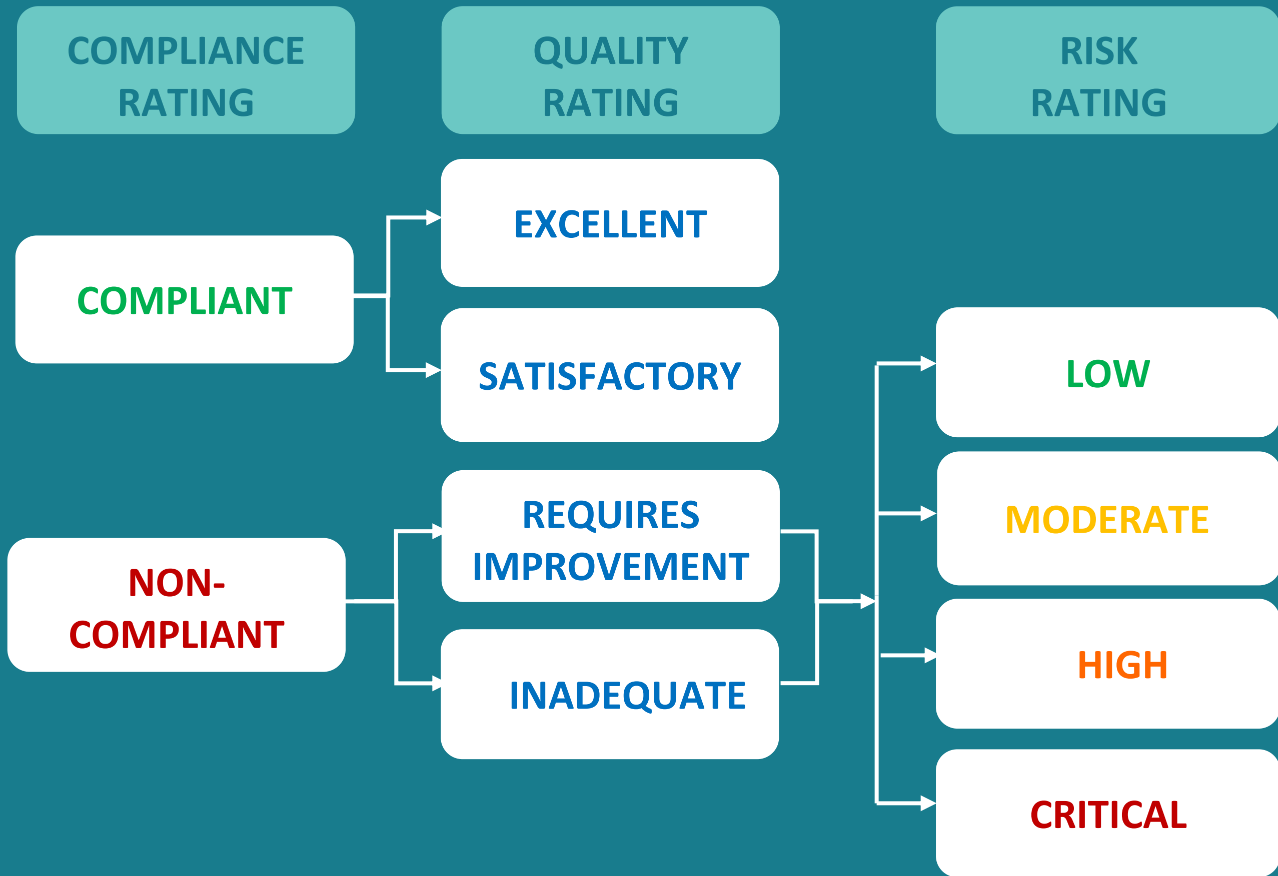
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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, achievable, realistic, 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.

In Brief

The Acute Mental Health Unit in Cork University Hospital was a 50-bed unit in the grounds of the Hospital. It opened in 2015. Its layout was modern with single en suite bedrooms and two double bedrooms. The approved centre's overall compliance with Regulations, Rules and Codes of Practice was 71%, a slight improvement from 69% in 2016. Of the non-compliances, 50% were rated as high risk. The approved centre had five regulations rated as excellent.

Safety in the approved centre

Although food safety audits had been completed periodically, the approved centre was non-compliant with food safety as food temperatures were not adequately recorded in line with food safety recommendations.

Prescription of medication was non-compliant for the third year in a row, each non-compliance rated as high risk.

While not all staff were trained in mandatory training, the approved centre had made considerable progress in training staff.

The assessment and management of risk was satisfactory and individual risk assessments for residents were completed. The clinical files were in very poor condition, which constituted a risk for residents.

Appropriate care and treatment of residents

The needs of residents identified as having special nutritional requirements were not reviewed by a dietitian. The approved centre did not have a dietitian and referral was on a good will basis only.

While each resident had a care plan, a number of these were not complete and therefore of little benefit to the resident. It is of note that the approved centre was non-compliant in individual care plans in 2016 and 2017 and now again in 2018; each year rated as high risk.

There was a wide range of therapeutic services and programmes on offer for residents, provided by the multi-disciplinary team and an activities nurse.

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Residents had access to national screening programmes appropriate to age and gender. There was a smoking cessation programme, and an individual smoking cessation plan was developed for residents who wished to avail of it.

One child had been admitted to the approved centre since the last inspection in 2017, for a duration of one overnight stay. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of the child.

The admission process was adequate but the discharge process was unsatisfactory.

Respect for residents' privacy, dignity and autonomy

It was evident that residents' privacy and dignity were respected. There were single en suite bedrooms and two double bedrooms. CCTV usage was carried out in a manner that respected residents' privacy and dignity. The entrance doors into the acute area and the access to the older person unit in the AMHU were accessible only via keypad or by staff releasing the electronic door mechanism on the days of inspection. The AMHU had access to a number of external and interior gardens, some of which were also locked at the time of inspection.

There were 20 searches implemented since the last inspection in 2017. All complied with Regulation 13: Searches.

Responsiveness to residents' needs

The approved centre had revised their service user pocket sized information booklet for residents, which was comprehensive. Information was available on medication and diagnoses. The complaints procedure was robust and there was a complaints officer. There was excellent access to recreational activities during the week and at weekends, and there was a daily and weekly timetable, which was displayed. Opportunities were provided for indoor and outdoor physical activity. Visiting times were flexible and there were no restrictions on communication. Whilst the residents had a choice of meals, there was no choice for those who were diabetic or those who required textured diet. Residents were not provided with appropriate emergency personal clothing that took into account the residents' preferences, dignity, bodily integrity, and religious and cultural practices. The property room had unsuitable second hand clothing.

Governance of the approved centre

There were clear governance structures and processes in place reflecting the Cork Mental Health Services within the HSE's Community Healthcare Organisation (CHO) Area 4. Each discipline provided a clear overview of the governance within their respective departments, which reflected the established governance mechanisms in place.

The Area Management Team met approximately every month and covered Quality and Patient Safety, Risk Register reports, staffing priorities, service development, and staff training and development. There was an action-oriented focus with clear time lines for completion of actions. This process was supported by strong governance locally through bi-monthly meetings of the Acute Adult Mental Health Unit management team, which considered delayed discharge reviews, bed list management, policy and audit activity, and admissions protocols.

The approved centre had effective processes in place in terms of incident monitoring, investigation and escalation where necessary, and risk management and complaints management. Supported continuous professional development (CPD) and reflective practice groups were used to facilitate staff development.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre has revised their service user pocket sized information booklet for residents.
2. Development of a crisis admission booklet.
3. Development work has commenced for admission guidelines on service users who present with emotionally unstable personality disorders.
4. A Quality Champion has been identified in implementing the HSE Best Practice Guidelines.
5. Learning was applied across the service from research on service user experience of ward based programmes.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Acute Mental Health Unit (AMHU) provided inpatient beds for the population needs of South Lee catchment area in Cork. The Unit was located within the grounds of Cork University Hospital campus in Wilton, Cork city. This purpose-built, two-storey building included a number of internal landscaped courtyards and opened in August 2015.

The approved centre comprised three units: the acute male unit, the acute female unit and the psychiatry of later life (POLL) unit. Both the acute male and female admission units, each with 18 beds, were located on the ground floor. The unit had provision for an additional six-bed high observation area on the ground floor. At the time of the inspection, the high observation area was not functioning as such; instead, the six beds were being used as additional beds for the admissions unit. The male and female admissions unit was configured into 21 beds for male occupants and 21 beds for female occupants.

The eight-bed POLL unit was located on the first floor alongside administration offices and therapy rooms. Visitors entered the premises through a large reception area which was staffed 24 hours' a day by HSE security personnel. The link corridor between the reception hallway and the admissions unit contained interview rooms and three visitors' rooms.

Six general adult sector teams and two POLL teams admitted residents to the AMHU.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**41**
Number of detained patients	5
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

Condition 1: To ensure adherence to *Regulation 15: Individual Care Plan*, the approved centre shall audit their individual care plans 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 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.

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

There was an organisational chart and clear governance structures and processes in place reflecting the Cork Mental Health service within the HSE's Community Healthcare Organisation (CHO) Area 4, which additionally comprises Kerry, North Lee, North Cork and West Cork services. Representatives from nursing, medical, social work, occupational therapy, and psychology each provided a clear overview of the governance within their respective departments, which reflected the established governance mechanisms in place.

The governance structures included an area executive management team, a local AMHU management team, a quarterly incident review committee, and a quality initiatives and audit committee. Copies of the minutes of the Cork Mental Health Services area management team meetings were provided to the inspection team. Inspection of the minutes showed that the management team met approximately every month and actively addressed issues such as quality and patient safety, risk register reports, staffing priorities, service development and staff training and development. The minutes demonstrated an action-oriented focus with clear time lines for completion of actions. This process was supported by strong governance locally through bi-monthly meetings of the AMHU management team in areas such as delayed discharge reviews, bed list management, policy and audit activity, and admissions protocols.

The unit had effective processes in place in terms of incident monitoring, investigation and escalation where necessary, risk management, and complaints management. All team members had access to either individual supervision or group supervision through their professional line manager or by way of funded external provision. This latter approach was often the case where specialist supervision was required for specific therapeutic interventions/practices. Supported continuous professional development (CPD) and reflective practice groups were used to facilitate staff development.

The Area Director of Nursing visited the approved centre on a regular basis. The Clinical Director was based in the approved centre and was on site daily. The Occupational Therapy Manager, Principal Psychologist and Social Work Manager had no direct input to the approved centre.

4.5 Use of restrictive practices

The entrance doors into the acute area and the access to the older person unit in the AMHU were accessible only via keypad or by staff releasing the electronic door mechanism on the days of inspection. The AAMHU

had access to a number of external and interior gardens, some of which were also locked at the time of inspection. It was reported that doors were not always locked and this was only undertaken in response to potential or actual risks internally or externally and for the minimum amount of time.

Residents were individually risk assessed and decisions regarding any restrictions would be discussed by the resident's multi-disciplinary team (MDT) and with the resident. Visiting times were flexible, except in the event of an infections outbreak, as was the case in the main hospital campus at time of inspection. Observed specific restrictions on visiting residents whilst in hospital was at the behest of a resident. Whilst the residents had a choice of meals, there was no choice for those who were diabetic or those who required textured B.

5.0 Compliance

5.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 5: Food and Nutrition	✓		✓		✗	Low
Regulation 6: Food Safety	✓		✓		✗	Moderate
Regulation 7: Clothing	✗	Low	✓		✗	Moderate
Regulation 15: Individual Care Plan	✗	High	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✗	High	✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	High	✗	Low	✗	Low
Code of Practice Relating to Admission of Children under the Mental Health Act 2001		Not Applicable		Not Applicable	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Moderate	✗	Low	✗	High

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.

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 13: Searches
Regulation 30: Mental Health Tribunals

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the child admitted to the approved centre was there short-term and did not require educational services, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

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

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

The inspection team met with seven residents, who provided information on their lived experiences within the unit. Two residents returned a completed questionnaire.

All residents were aware of their multi-disciplinary team and had the opportunity to partake in the care and recovery planning process. Nearly all were complimentary of staff, describing them as kind and caring. All had a key nurse and all liked their bedroom facilities and enjoyed the food. Residents felt safe, and could identify an aspect of their therapeutic programmes that was of value to them. Where any resident brought a matter to the attention of the inspectors during the inspection process, that query or concern was relayed to clinical and/or administrative staff who undertook to follow it up.

Contact was also made with the IAN who were unable to meet the inspection team on this occasion.

7.0 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:

- Acting Clinical Director
- Acting Social Work Team Leader
- Acting Head of Service
- Acting Assistant Director of Nursing
- Acting Clinical Nurse Manager 3
- Acting Clinical Nurse Manager X 2
- Clinical Nurse Manager 2
- Occupational Therapy Manager
- Principle Clinical Psychologist
- Area Director of Nursing

Apologies were acknowledged from the Safety and Risk Advisor, Clinical Director, and Area Lead for Mental Health Engagement.

Acknowledgement and thanks was given to all the clinical heads of discipline who had made themselves available to speak with the inspectors and those that facilitated the inspection process. 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.

A number of other clarifications were provided regarding various issues that had arisen during the course of this inspection, and these are incorporated into this report.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The identifiers, detailed in residents' clinical files, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

All residents were offered identity wristbands on admission; however, not all residents chose to wear one. The approved centre used the name, date of birth, and medical record number of each resident as identifiers. The identifiers used were person-specific and did not include a room number. There was a red sticker label alert system in place on clinical files to help staff in distinguishing between residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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 two written policies in relation to food and nutrition. The food and nutrition policy was last reviewed in February 2017. The mealtime management policy was last reviewed in October 2016. The policies included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Hot and cold drinks were offered to residents regularly. There was no daily meal choice for people with diabetes or for residents on texture B/pureed food diets. At the time of the inspection, an evidence-based nutrition screening tool, St. Andrew's Nutritional Screening Instrument (SANSI), was in the process of being introduced and, however, had not yet been used. There was no documented evidence to show that residents, their representatives, family, and next of kin were educated about residents' diets and associated contraindications with medication.

Nutritional and dietary needs were not assessed except in occasional circumstances. There were swallow diets posted on the wall for some residents with special requirements, but there was no copy of this recorded in clinical files or individual care plans. The needs of residents identified as having special nutritional requirements were not reviewed by a dietitian. The approved centre did not have a dietitian and referral was on a good will basis only. There were a number of residents on modified consistency diets, and there was no record of this in their individual care plans. At interview, the residents complimented the food; however, one resident felt that sometimes mealtimes were rushed and trays were cleared before a resident had finished.

The approved centre was non-compliant with this regulation because there was no element of daily meal choice for residents with diabetes and residents on texture B/pureed food diets, 5 (1).

Regulation 6: Food Safety

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(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 February 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

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

Evidence of Implementation: Breakfast was prepared in the approved centre, and food for dinner and tea was prepared in Cork University Hospital and transported to the approved centre. There was suitable and sufficient catering equipment. Hygiene was maintained to support food safety requirements. There were appropriate hand-washing facilities for catering services. Staff wore appropriate personal protective equipment during the catering processes.

Food temperatures were not recorded in line with food safety recommendations from the Environmental Health Officer's report of the approved centre dated the 22nd November 2017, which had identified this practice as part of their hazard analysis. The report stated "the reheating of food is not risk assessed", "this practice shall be risk assessed", "this risk assessment shall be documented and be maintained on site for inspection" and "the identified non-compliance must be rectified as soon as possible".

On inspection, there was no evidence that any risk assessments, as required above, had been undertaken. There was no system in place to regularly check and record the temperature of food prior to it being served. On inspection, a trolley was found with three dinners on it, which were due to be reheated in a microwave. When food was reheated in a microwave, there was no probe used to check the temperature.

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

a) The reheating of residents' meals was not risk assessed 6.2(c).
b) Food temperatures were not recorded in line with food safety recommendations6.2(c).

Regulation 7: Clothing

NON-COMPLIANT

Quality Rating **Requires Improvement**
Risk Rating **MODERATE**

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 residents' clothing, which was last reviewed in February 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. A record of residents wearing nightclothes during the day was maintained and monitored.

Evidence of Implementation: Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans. Residents had an adequate supply of individualised clothing and all residents' clothing was clean and appropriate to the residents' needs.

Residents were not provided with appropriate emergency personal clothing that took into account their preferences, dignity, bodily integrity, and religious and cultural practices. The property room had unsuitable second hand clothing. At the time of the inspection, a process to procure clothing had been initiated but was not in place.

There were no laundry facilities in the approved centre. Residents had to bring clothing to a local launderette, which was difficult for residents to do when they were in need of assistance. Other residents sent clothes home to be cleaned with family, when possible.

The approved centre was non-compliant with this regulation because residents were not provided with an appropriate supply of emergency personal clothing, 7 (1).

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in October 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process to allow residents access to and control over their personal property and possessions.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were not monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre had two safes for residents' monies. Residents accessed their money through a designated staff member. Residents' monies handled by staff were signed for by two staff members. In some cases residents signed also.

The approved centre compiled a detailed property checklist with each resident on admission, listing their personal property and possessions. The checklist was not updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to each resident's individual care plan and was available to the resident. Residents were supported to manage their own property, once it was safe to do so.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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 February 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile during the week and at weekends. Information on recreational activities was in an accessible format, through a daily and weekly timetable, which was displayed on each individual unit of the approved centre. Residents' views on recreational activities were considered by staff at resident meetings, which were held every two to three weeks.

Opportunities were provided for indoor and outdoor physical activity. The activities available in the psychiatry of later life unit included bingo, music, ball games, news and views group, radio, knitting, card games, and arts and crafts. Residents had access to a newly refurbished rooftop patio area, which included raised planter beds and a small space for walking. There was also a multi-sensory room.

The acute admission unit had three lounges, each with a TV. Residents had access to a daily newspaper, magazines, books, board games, and arts and crafts. There was a news and views group each morning and a walking group twice a week, which were facilitated by the activities nurses. Residents could use an indoor gym if they wished. An occupational therapy student and social work student ran a weekly baking group. Communal areas were provided that were suitable for recreational activities. Attendance at recreational activities was documented within each resident's clinical file.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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 February 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. There were facilities available to support residents' religious practices including a chapel in the general hospital. Residents had access to multi-faith chaplains. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

(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. The policy was last reviewed in February 2017. The policy included the requirements of the *Judgement Support Framework,* with the exception of the required visitor identification methods.

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

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: There were no visiting restrictions implemented for any residents at the time of the inspection. Appropriate and reasonable visiting times were publicly displayed. Four dedicated visitor rooms were available in the approved centre where residents could meet visitors in private, unless there was an identified risk to the resident or to others, or a health and safety risk. Three visiting rooms were located upstairs and one downstairs. Visitors were not permitted to go onto the wards.

Where a resident did not wish to see a particular relative, this was written on the ward whiteboard and security were informed; however, the resident's clinical file did not record the name of the visitor who the resident did not wish to see.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times. This was communicated to all relevant individuals publicly. The visiting rooms available were suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities for resident communication processes.
- Circumstances in which resident communications may be examined by a senior member of staff.
- The individual risk assessment requirements in relation to limiting resident communication activities.

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: The approved centre did not complete individual risk assessments in relation to any risks associated with residents' external communications; the approved centre considered this unnecessary and not applicable to the current resident cohort. Relevant senior staff only examined incoming and outgoing resident communication if there was reasonable cause to believe the resident or others may be harmed.

Residents had access to communication devices, unless otherwise risk assessed with due regard to the residents' wellbeing, safety and health. Residents could use mail and fax. The approved centre did not provide Wi-Fi internet to residents. They could use their own personal mobile and the ward's portable phone for making private phone calls.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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 operational policy in relation to the implementation of resident searches. The policy was last reviewed in October 2016. The policy addressed 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 is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

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

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. One clinical file and accompanying search form was inspected in relation to one resident who had been searched since the last inspection. Risk had been assessed prior to the search of the resident and their belongings. Resident consent and agreement to being searched was sought and documented.

The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. Searches were implemented with due regard to the resident’s dignity, privacy and gender; at

least one of the staff members who conducted the search was the same gender as the resident being searched. Search forms were completed and documented in the clinical file inspected.

There were 20 searches implemented since the last inspection. A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search. There had been no environmental searches in the approved centre since the last inspection.

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

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

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

Monitoring: There had been no sudden or unexplained deaths in the approved centre since the last inspection. End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: One expected death, which had occurred in the approved centre since the last inspection, was reviewed. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs, and this was documented in the resident's individual care plan. Religious and cultural practices were respected. The privacy and dignity of the resident was protected. The resident was provided with a single bedroom within the approved centre at end of life. Representatives, family, next-of-kin, and friends of the resident were involved, supported, and accommodated during end of life care. The resident's death was reported to the Mental Health Commission within the required 48-hour timeframe.

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in February 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Residents' ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Each resident had an ICP. Ten ICPs were inspected. All ten inspected were a composite set of documentation, which included allocated spaces for goals, treatment, care, and resources required. Each resident had been assessed at admission by the admitting clinician who completed an ICP to address immediate needs of the resident. All ten residents received an evidenced-based comprehensive assessment within seven days of admission. In five care plans inspected, the ICPs were not developed by the MDT.

The resident's family did not participate in any of the ten ICPs inspected. Two ICPs were not signed by the resident. One ICP was not drawn up with the resident's involvement. The resident had declined to be involved in the ICP process and this was documented. Three ICPs did not identify the resident's assessed needs. Seven ICPs did not identify appropriate goals for the resident. Four ICPs did not identify appropriate interventions. Six ICPs did not identify the resources required to provide the care and treatment identified. One resident found the MDT meeting and process intimidating, stating that it was "full of authority figures".

In all ten ICPs inspected, a key worker was identified to ensure continuity in the implementation of a resident's ICP. Each ICP inspected included an individual risk management plan. One ICP did not include a preliminary discharge plan, where deemed appropriate. The ICP was reviewed by the MDT in consultation with the resident on a weekly basis; however, the approved centre staff were rewriting the ICP each week.

The ICPs were not always updated following review, as indicated by the residents' changing needs, condition, circumstances and goals. A number of teams on the psychiatry of later life unit were not filling out the review sheet and were leaving it blank.

All residents had access to their ICPs and were kept informed of any changes. None of the ten residents was offered a copy of their ICP, including any reviews, and no reason for this was documented in any of the ICPs inspected.

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

a) **Not all care plans identified appropriate goals for each resident.**
b) **Not all care plans identified the care and treatment required to meet the goals identified.**
c) **Not all care plans clearly identified the resources required to provide the care and treatment identified.**
d) **All ICPs were not completed in consultation with residents.**
e) **Not all care plans were developed, regularly reviewed and updated by the resident's MDT, as indicated by the resident's changing needs, condition, circumstances, and goals.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in February 2017. The policy included all of the requirements of the *Judgement Support Framewor*k, with the exception of the facilities for the provision of therapeutic services and programmes.

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

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: A range of therapeutic programmes was available to residents. The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in residents' individual care plans. The services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of all therapeutic services and programmes provided in the approved centre was available to residents. Group therapies offered to residents included art therapy, drama therapy, and an off-site Hearing Voices group which works to empower individuals with voices, vision and other unusual experiences or beliefs which residents could access by referral. The activities nurses ran groups such as recovery, relaxation, walking, news and views, a sensory session, communication, and arts and crafts. Psychology staff delivered a psychology skills group three times a week and topics included understanding emotions, developing self-compassion, anxiety management, mindfulness, sleep hygiene, and exploring character strengths.

In relation to individual therapeutic services and programmes, residents had access to occupational therapy, social work, and clinical psychology on an individual basis as required. The clinical files evidenced residents received input from dietetics, physiotherapy and speech and language therapy as required.

Adequate resources and facilities were available to provide therapeutic services and programmes. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

There were separate dedicated rooms containing facilities and space for individual and group therapies. A record was maintained of participant, engagement, and outcomes achieved in therapeutic services or programmes within each resident's clinical file.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

(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 and procedures in relation to the transfer of residents. The policy was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for managing resident medications during transfer from the approved centre.

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented 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 had been transferred from the approved centre was examined. Communication records with the receiving facility were not documented, and their agreement to receive the resident in advance of the transfer was not documented.

Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks. There was no record to indicate the resident's accompaniment requirements on transfer.

The resident was risk assessed prior to the transfer, and documented consent of the resident to the transfer was available. Written information was issued as part of the transfer, including a letter of referral, and the resident transfer form.

A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents' 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, and evidence of implementation pillars.

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in February 2017. The medical emergencies policy was last reviewed in February 2017. The policies and procedures addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The staff training requirements in relation to Basic Life Support.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The documentation requirements in relation to general health assessments.
- Access to national screening programmes available for residents through the approved centre.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review was undertaken by the Delayed Discharge Group to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency resuscitation trolley on each unit; each trolley included an Automated External Defibrillator (AED). The emergency equipment was checked weekly.

Four clinical files were inspected. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required.

Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre. Residents had access to smoking cessation supports. On admission, residents were advised of the smoke free unit policy and information on the policy was available in the information booklet. Residents

were offered help to manage smoking cessation, and an individual smoking cessation plan was developed for residents who wished to avail of it. Referral to the health promotion smoking cessation service was also offered as further support.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for identifying residents' preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with an in-patient handbook that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition.

Medication information sheets as well as verbal information were provided in a format appropriate to the residents' needs. The content of medication information sheets includes information on indications for use of all medications to be administered to residents, including any possible side-effects.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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 February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre layout and furnishing requirements to support resident privacy and dignity.
- The approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: The general demeanour of staff and the way in which staff addressed and communicated with residents was respectful. Staff were discreet when discussing the residents' condition or treatment needs. Staff knocked before entering residents' rooms. Residents were dressed appropriately to ensure their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

Residents were accommodated in single bedrooms with en suite facilities, with the exception of two double bedrooms, which were shared. Where the resident shared a room, the bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were made of opaque glass. At resident interviews, a number of residents reported being moved during the night to another bedroom without being asked for permission first. Additionally, noise levels on the unit and night staff switching on lights during night-time observation rounds were disrupting sleep hygiene.

Rooms were not overlooked by public areas, and there were new privacy screens on the approved centre's internal courtyard since the last inspection. Noticeboards did not display any identifiable resident information. Residents were facilitated to make and receive private phone calls

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in October 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre's utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.

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

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: All resident bedrooms were appropriately sized to address the residents' needs. Sleeping accommodation was in 46 single, en suite rooms, and two double bedrooms. There was a sufficient number of toilets and showers for residents. Toilets were accessible and clearly marked. The toilet located close to the day and dining area was not for residents' use. It was a wheelchair assisted toilet and was locked because of ligatures associated with assistive equipment.

Accommodation for each resident assured comfort and privacy and met assessed needs. An assisted device had been installed in the bathroom of one resident to address their needs.

While the approved centre had adequate storage space, some clinical equipment and patient mobility aids were stored inappropriately, either within incorrect storage areas, or on corridors.

There were appropriately sized communal rooms in the approved centre. There was suitable and sufficient heating in bedroom and day areas. Rooms were ventilated. The lighting in communal rooms met the needs of residents and staff. It was sufficiently bright to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs.

Residents were provided with sufficient spaces to move about, including outdoor spaces. There were three separate resident gardens and a further non-accessible garden for visual appeal purposes. There was also one staff garden. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised. The approved centre was kept in a good state of repair externally and internally.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained for each. The approved centre was clean, hygienic, and free from offensive odours.

The approved centre was compliant with this regulation. The quality 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 23: Ordering, Prescribing, Storing and Administration of Medicines

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

Processes: The approved centre had four written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication. The policy on administration and storage was last reviewed in February 2017. The policy on supplying emergency medication was last reviewed in June 2013. The policy on medication errors was last reviewed in June 2013. The policy on leave of absence medication was last reviewed in April 2015.

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

- The process for administering controlled drugs, including checks and records required.
- The process for self-administration of medication.
- The process for medication reconciliation.
- The process for reviewing resident medication.

Training and Education: Not all nursing, medical and pharmacy staff had signed the signature log to indicate that they had read and understood the policies. All nursing, medical staff and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Nursing and medical staff as well as pharmacy staff had not received training on the importance of reporting medication incidents, errors, or near misses.

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

Evidence of Implementation: Each resident had an MPAR, and 10 of these were inspected. Each MPAR inspected evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR. A record was kept when medication was refused by or withheld from the resident.

Of the ten MPARs reviewed, five did not detail discontinuation of medication dates, and associated medical practitioner's signature with all stopped medications. In some instances, this pertained to a number of medications contained in one MPAR. Seven MPARs did not record residents' allergies or sensitivities to any medications, or include if the resident had no allergies.

All entries in the MPAR were legible, and written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber. Advice on how to administer medication was not routinely given by the resident's pharmacist, but was provided if requested by the approved centre. The expiration date of the medication was checked prior to administration, and expired medications were not administered. Medication was reviewed and rewritten every two weeks.

All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members prior to administration. The use of appropriate resident identifiers and good hand-hygiene and infection control techniques were observed during the administration of medication.

Medication was stored in the appropriate environment, as advised by the pharmacist. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. Food and drink was not stored in areas used for the storage of medication. An inventory of medications was not conducted on a monthly basis, checking the name and dose of medication, quantity of medication, and expiry date.

Medications that were no longer required, which were past their expiry date or had been dispensed to a resident were no longer required were stored in a secure manner, segregated from other medication, were returned to the pharmacy for disposal.

The approved centre was non-compliant with section 1 of this regulation for the following reasons:

a) **Five MPARs did not detail discontinuation of medication dates, and associated medical practitioner's signature with all discontinued/stopped medications.**
b) **Seven MPARs did not record residents' allergies or sensitivities to any medications, or include if the resident had no allergies.**

Regulation 24: Health and Safety

COMPLIANT

(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 series of written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in February 2017. The policies addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in February 2017. The policy addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The maintenance of CCTV cameras by the approved centre.
- Ensuring the use of CCTV in the approved centre is overt and clearly identifiable through the use of signage and communication with residents and/or their representatives.

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: The Mental Health Commission had been informed about the approved centre’s use of CCTV. There were clear signs in prominent positions where CCTV cameras were located. Residents was monitored solely for the purpose of ensuring their health, safety, and welfare. The cameras were incapable of recording or storing a resident’s image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	HIGH

(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 and procedures in relation to its staffing requirements. The policy was last reviewed in February 2017. The policy and procedures addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

Training and Education: Relevant staff had signed the signature log to indicate 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 implementation and effectiveness of the staff-training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place, which identified the leadership and management structure and the lines of authority and accountability of the approved centre's staff. The numbers and skill mix of staffing were sufficient to meet resident needs. A significant number of senior staff aligned to or working within the approved centre were noted to be in acting positions. A dedicated occupational therapy position and a principal social worker position for the approved centre were awaiting approval at the time of the inspection.

Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment. Information from referees was sought and documented. Where agency staff were used, there was a comprehensive contract between the approved centre and registered/licensed staffing agency.

A written staffing plan was available which considered the assessed needs of the resident group profile of the approved centre. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. This was documented.

Staff were trained in areas such as infection control and prevention, including sharps, hand hygiene techniques, use of personal protective equipment, manual handling, risk management, care for residents with an intellectual disability, recovery centred approaches to mental health care and treatment, and the protection of children and vulnerable adults.

Not all health care staff were trained in the following:

- Fire safety (70% of staff were trained)
- Basic Life Support (70% of staff were trained)
- Management of violence and aggression (98% of nursing staff were up to date)
- The Mental Health Act 2001. (70% of staff were trained)
- Children First

All staff training was documented and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre:

Ward or Unit	*Staff Grade*	*Day*	*Night*
Psychiatry of Later Life	CNM1 RPN HCA	1 2 1	* 2 1

Ward or Unit	*Staff Grade*	*Day*	*Night*
West	CNM1 RPN HCA	1 4 *	1 3 *

Ward or Unit	Staff Grade	Day	Night
East	CNM1 RPN HCA	1 4 *	* 3 1

Ward or Unit	Staff Grade	Day	Night
Nurse Therapy Department	RPN	2 *	* *

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

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

a) **Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, Children First, 26(4).**
b) **Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

(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.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

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 and procedures in relation to the maintenance of records. The policy was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The required resident record creation and content.
- Record review requirements.
- Privacy and confidentiality of resident record and content.
- Residents' access to resident records.
- Record retention periods.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. However, the audits did not identify issues such as loose pages in files, and the absence of file dividers. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Resident records reflected the residents' status at the time of inspection and the care and treatment being provided. Records were not constructed, maintained and used in accordance with national guidelines and legislative requirements. A number of clinical files contained loose pages. Documents were frequently not filed in the correct order. There were no dividers in one clinical file. There was no documentation in relation to nutritional and dietary needs within the clinical file assessments.

Not all resident records were physically stored together. Swallow care plans were on the wall and in the kitchen but were not stored in the clinical file. Resident records were not always maintained using an identifier that was unique to the resident. Records frequently evidenced no identifier. In addition, some records detailed one resident identifier and did not detail two appropriate resident identifiers.

Resident records were not developed and maintained in a logical sequence; documentation was often in the wrong place. The approved centre did not maintain a record of all signatures used in the resident record. Entries on residents' records were factual, consistent, and accurate but the name of the medical professional and medical record number was not on every single page of each file. Hand-written records were legible and written in black indelible ink and were readable when photocopied. However, each entry did not include the date and the time using the 24-hour clock. Records were appropriately secured throughout the approved centre.

Residents' records were accessible to authorised staff only, and only authorised staff made entries in them. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was non-compliant with section 1 of this regulation because records were not maintained in a manner to ensure completeness, accuracy and ease of retrieval. All records were not kept up-to-date and in good order because:

a) **Records were not constructed, maintained and used in accordance with national guidelines and legislative requirements. A number of clinical files contained loose pages.**
b) **Documents were frequently not filed in the correct order. There were no dividers in one clinical file.**
c) **There was no documentation in relation to nutritional and dietary needs in clinical file assessments.**
d) **Not all resident records were physically stored together.**
e) **Records frequently evidenced no identifier. Some records detailed one resident identifier and not two appropriate resident identifiers.**
f) **Resident records were not developed and maintained in a logical sequence; documentation was often in the wrong place.**
g) **The approved centre did not maintain a record of all signatures used in the resident record.**
h) **Each medical record entry did not include the date and the time using the 24-hour clock.**

Regulation 28: Register of Residents

COMPLIANT

(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 three documented up-to-date registers of residents admitted; one register for each of the three wards. The three registers contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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 in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in October 2016. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The standardised operating policy and procedure layout used by the approved centre.

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

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

Where generic policies were used, the approved centre had a written statement adopting the generic policy and the statement was reviewed every three years.

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 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

(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 and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in February 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

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

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. It had a dedicated tribunal room, waiting room, a bathroom, and toilet facilities. There was an additional room available for the legal representative to use.

The approved centre provided adequate resources, including a dedicated Mental Health Act administrator, to support the Mental Health Tribunal process. Staff accompanied and assisted patients to attend their Mental Health Tribunal as required.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in November 2017. In addition, the approved centre used the HSE's *Your Service, Your* Say complaints policy and process. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. However, complaints data was not analysed for senior management to consider. Required actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected because of the complaint being made. All complaints were dealt with by the nominated person and recorded in the

complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. The complainant's satisfaction or dissatisfaction with the investigation findings was documented.

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 staff training and education, and monitoring pillars.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework*, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.

The policy did not address the following:

- The roles and responsibilities of the registered proprietor in relation to risk management.
- The person with overall responsibility for risk management.

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

Monitoring: The risk register was not reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The risk register was reviewed and updated regularly, including recording of new risks as identified and it contained mitigation or control actions to address

identified risks within the time frames in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: All staff were responsible for risk, including the safety and risk advisor. Staff were aware of this. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Clinical risks were identified, assessed, treated, monitored, and recorded in the risk register; however, inappropriately stored clinical equipment and patient mobility aids were observed on corridors and near emergency exits. These items may have led to trips, impeded the way out from the building, or presented a potential ligature risk.

Individual risk assessments were completed in advance of episodes of resident seclusion and physical restraint, with the aim of identifying individual risk factors. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks and health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre and were documented in a risk register.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures, including procedures for evacuating wheel-chair users.

Access within the approved centre was mostly by means of swipe card. However, it was observed that a number of stores and toilet areas required different keys. This may pose a risk in terms of delay in the event of a fire, when searching for a missing resident, or in the efficient day-to-day working of the unit.

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 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

Quality Rating **Satisfactory**

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. The certificate was displayed prominently in the entrance foyer of the approved centre. The certificate of registration was for their previous date of registration, i.e., 4 February 2015.

This was accepted as the new Certificate of Registration for the approved centre was in the process of being finalised. However, it was not to be issued to the registered proprietor nominee before the end of this scheduled inspection.

There were to be two conditions attached to the new certificate based on last year's inspection (Regulation 15: Individual Care Plan and Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines).

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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 clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. The patient was unable to consent to treatment. The *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable To Consent* contained in the clinical file of this patient who did not consent to treatment evidenced the following:

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

All forms were completed within the appropriate time frame.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

11.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was not reviewed annually. The policy included the provision of information to the resident. The policy did not address:

- Who can initiate and who may implement physical restraint.
- Child protection processes where a child is physically restrained.

There was a separate training-related policy, which did not specify the frequency of training, and did not identify appropriately qualified persons to give the training. Physical restraint was not used to ameliorate staff shortages.

Training and Education: The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy. A record of training was maintained.

Monitoring: The approved centre forwarded the relevant annual report to the MHC.

Evidence of Implementation: The files of three residents who had been physically restrained were reviewed. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident’s unsafe behaviour. In all cases, the restraint order lasted for less than 30 minutes.

Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint. In two cases examined, residents’ next of kin were not informed about the physical restraint and the reasons for not informing them was only documented in one case. Each of the three residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. The resident was given the opportunity to discuss the episode with members of MDT as soon as was practicable.

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

a) **The physical restraint policy was not reviewed annually, 9.2 (d).**
b) **The physical restraint policy did not include:**
   - Who can initiate and who may implement physical restraint, 9.2, (d).
   - Child protection process where a child is physically restrained, 11.2.
c) **The training-related policy which did not specify the frequency of training, 10.1 (C), and it did not identify appropriately qualified persons to give the training, 10.1 (d).**

Admission of Children

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place in relation to the admission of a child, which was last reviewed in February 2017. There was a policy requiring each child to be individually risk assessed. Policy and procedures were in place with regard to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: There was one child admitted to the approved centre since the last inspection for a duration of one overnight stay. The child did not require educational services. The approved centre was an adult centre. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.

Provisions were in place to ensure the safety of the child, and to respond to a child's special needs as a young person in an adult setting. A designated staff member was assigned to the child. The approved centre had protocols in place to ensure the right of the child to have his/her views heard. The Child and Adolescent Mental Health Service were available by phone contact, to the approved centre.

Copies of the Child Care Act 1991, Children Act 2001 and Children First guidelines were available to relevant staff. All staff having contact with the child had undergone Garda vetting. Consent for treatment was obtained from one or both parents.

The child did not have access to age-appropriate advocacy services, as they were not available for residents without private health insurance. The Mental Health Commission were notified of the child's admission within 72 hours of admission, using the associated notification form.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5 (b).

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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 written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in October 2017, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in February 2017, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in October 2016, included the policy-related criteria for this code of practice, with the exception of the procedure for the discharge of involuntary patients.

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

Monitoring: Audits had been completed on the implementation of and adherence to the admission, discharge and transfer policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. The decision to admit was made by the registered medical practitioner (RMP)/consultant psychiatrist. The admission assessment was comprehensive and included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information, such as work situation, education and dietary requirements. All assessments and examinations were documented within the clinical file, and the resident was assigned a key worker.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The file of one resident who was discharged was inspected. A discharge plan was not in place as part of the individual care plan (ICP). Instead there was a discharge summary in place, which included the estimated date of discharge and a follow up out-patient appointment. It did not include documented communication with the primary care team, or a reference to early warning signs of relapse and risks.

A comprehensive discharge summary was not issued within 14 days. As there was no discharge plan recorded, the following discharge information was not recorded either: details of the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

There was no documented record of the resident's family member, carer, or advocate being involved in the discharge process. A timely follow up appointment was arranged for the resident.

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

a) **The discharge policy did not include the procedure for the discharge of involuntary patients, 4.2.**
b) **Audits had been completed on the implementation of and adherence to the admission and discharge policies but not the transfer policy, 4.19.**
In relation to discharge:
c) **Communication with the primary care team, a reference to early warning signs of relapse and risks; was not documented, 34.2.**
d) **A pre-discharge meeting did not address a current mental state examination, a comprehensive risk assessment and risk management plan, or the resident's informational needs, 35.1.**
e) **A preliminary discharge summary was not sent to the general practitioner/primary care/CMHT within three days, 38.3.**
f) **A comprehensive discharge summary was not issued within 14 days, 38.3, b.**
g) **As there was no discharge plan recorded, the following discharge information was not recorded: details of the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse, 38.4.**
h) **There was no documented record of the resident's family member, carer, or advocate involved in the discharge process, where appropriate, 39.1.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 5: Food and Nutrition

Report reference: Page 19

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
1. There was no element of daily meal choice for residents with diabetes and residents on texture B/pureed food diets, 5 (1).	*New*	*Plan required*	Corrective Action(s): Head of Catering has been emailed – awaiting updated policy on nutritional guidelines to be issued. Post-Holder(s) responsible: Flo Dupas (ADON) Michelle Murphy (CNM3)	Awaiting response from Ann Bodley (Head of Catering) re: same	Achievable	First week of October
			Preventative Action(s): Regular audits against JSF criteria of Regulation 5 Post-Holder(s) responsible: Flo Dupas (ADON) Michelle Murphy (CNM3)	Audits against JSF criteria of Regulation 5	Achievable	First week of October

Regulation 6: Food Safety

Report reference: Page 20-21

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
2. The reheating of residents' meals was not risk assessed 6.2(c).	*New*	*Plan required*	Corrective Action(s): Reheating of meals has ceased on the unit. Post-Holder(s) responsible:	n/a	n/a	n/a
			Preventative Action(s): Reheating of meals has ceased on the unit. Post-Holder(s) responsible:	n/a	n/a	n/a
3. Food temperatures were not recorded in line with food safety recommendations 6.2(c).	*New*	*Plan required*	Corrective Action(s): Flo Dupas in contact with Ann Bodley, Cathering Officer. HACCP training has been completed by all household staff. Post-Holder(s) responsible: Flo Dupas (ADON)	Food probes in use on a daily basis for monitoring food temperatures.	Achievable	Ongoing
			Preventative Action(s): Food probes will be used to monitor food temperature. CUH kitchen to be alerted when readings are inadequate. Post-Holder(s) responsible: Flo Dupas (ADON)	Audit to be conducted in 3 months time	Achievable	Ongoing

Regulation 7: Clothing

Report reference: Page 22

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*New plan; plan carried over from 2017 or monitored as per Condition*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
4. Residents were not provided with an appropriate supply of emergency personal clothing, 7 (1).	*New*	*Plan required*	Corrective Action(s): Monitoring system put in place to ensure that there is an adequate supply of clothing on the unit Post-Holder(s) responsible: Michelle Murphy (CNM3)	Bi-monthly audits on Regulation 7	Achievable	ongoing
			Preventative Action(s): adequate supply of clothing on the unit Post-Holder(s) responsible: Michelle Murphy (CNM3)	Bi-monthly audits on Regulation 7	Achievable	Ongoing

Regulation 15: Individual Care Plan

Report reference: Page 31-32

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*New plan; plan carried over from 2017 or monitored as per Condition*				
5. Not all care plans identified appropriate goals for each resident. 6. Not all care plans identified the care and treatment required to meet the goals identified. 7. Not all care plans clearly identified the resources required to provide the care and treatment identified. 8. All ICPs were not completed in consultation with residents. 9. Not all care plans were developed, regularly reviewed and updated by the resident's multi-disciplinary team, as indicated by the resident's changing needs, condition, circumstances, and goals.	*Reoccurring (#5 and #7)*	*Monitored as per Condition*[1]				

[1] To ensure adherence to *Regulation 15: Individual Care Plan*, the approved centre shall audit their individual care plans 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.

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Report reference: Page 43-44

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
10. Five MPARs did not detail discontinuation of medication dates; and associated medical practitioner's signature with all discontinued/stopped medications. 11. Seven MPARs did not have a record of allergy to medication status, or any sensitivities to any medications, including if the resident had no allergies.	*Reoccurring (#10)*	*Monitored as per Condition*[2]				

[2] To ensure adherence to *Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines*, the approved centre shall audit their Medication Prescription and Administration (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.

Regulation 26: Staffing

Report reference: Page 47-49

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
12. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, Children First, 26(4). 13. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccurring*	*New Plan Required*	Corrective Action(s): All Heads of Discipline have been emailed outling requirement of mandatory training and ensure that same is up-to-date Post-Holder(s) responsible: all head of Discipline	This is the responsibility of each Head of Discipline to ensure that staff members under their remit are up-to-date with their required training.	Achievable	ongoing
			Preventative Action(s): Need for mandatory training will be discussed with NCHD during induction process Post-Holder(s) responsible: Dr Karen O'Connor and Dr Aoife Ni Chorcorain	Certification required as part of the induction process	Achievable	ongoing

Regulation 27: Maintenance of Records

Report reference: Page 50-51

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
14. Records were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records were not kept up-to-date and in good order because: • Records were not constructed, maintained and used in accordance with national guidelines and legislative requirements. A number of clinical files contained loose pages. • Documents were frequently not filed. There were no dividers in one clinical file. • There was no documentation in relation to nutritional and dietary needs in clinical file assessments. • Not all resident records were physically stored together. • Records frequently evidenced no identifier. Some records detailed one resident identifier and not two appropriate resident identifiers. • Resident records were not developed and maintained in a logical sequence: documentation was often in the wrong place. • The approved centre did not maintain a record of all signatures used in the resident record. • Each medical record entry did not include the date and the time using the 24-hour clock.	*Reoccurring*	*Please provide a detailed plan on how the service intends to address the findings in relation to the maintenance of records in the approved centre*	Corrective Action(s): Information sessions facilitated by staff officer outlining process of maintaining file (1 of 2 completed by 27/9/18) Post-Holder(s) responsible: Clinical Director, Michelle Murphy (CNM3) and administration staff	Spot-check to be completed regularly. Audit to be led by clinical director in 3 months to review progress.	Achievable	ongoing
			Preventative Action(s): Spot-check to be completed regularly. Post-Holder(s) responsible: Clinical Director, Michelle Murphy (CNM3)	Audit to be led by clinical director in 3 months to review progress.	Achievable	ongoing

Code of Physical Practise: Use of Physical Restraint

Report reference: Page 66

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
15. The physical restraint policy was not reviewed annually, 9.2 (d).	*New*	*Plan required*	Corrective Action(s): complete Post-Holder(s) responsible: Michelle Murphy (CNM3)	Will be annually reviewed	Achievable	March 2019
			Preventative Action(s): Will be reviewed annually Post-Holder(s) responsible: Michelle Murphy (CNM3)	Will be annually reviewed	Achieveable	March 2019
The physical restraint policy did not include: 16. Who can initiate and who may implement physical restraint, 9.2, (d). 17. Child protection process where a child is physically restrained 11.2. 18. The training-related policy which did not specify the frequency of training, 10.1 (C), and it did not identify appropriately qualified persons to give the training, 10.1 (d).	*Reoccurring*	*New plan required*	Corrective Action(s): Meeting will be held to discuss and update to include issues raised. Post-Holder(s) responsible: Michelle Murphy (CNM3), Flo Dupas (ADON) and PMAV instructors.	Will be scheduled within 2 weeks	Achievable	ongoing
			Preventative Action(s): Email sent to arrange meeting Post-Holder(s) responsible: Michelle Murphy (CNM3), Flo Dupas (ADON) and PMAV instructors	Will be scheduled within 2 weeks	Achievable	ongoing

Code of Practice: Admissions of Children

Report reference: Page 67

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
19. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5 (b).	*New*	*Plan required*	Corrective Action(s): Liaising with ADON of CAMHS Is seeking guidance as to how to meet the educational needs of children. Liaising with nursing therapy department on AMHU to ascertain if age appropriate services can be provided. Post-Holder(s) responsible: Flo Dupas (ADON)	Awaiting response re: same	Achievable	ongoing
			Preventative Action(s): Copy of *Headspace* a mental health toolkit has been received from the CAMHS service. ADON at CAMHS will facilitate workshops on AMHU Re: same Post-Holder(s) responsible: Flo Dupas (ADON)	Awaiting response re: same	Achievable	ongoing

Code of Practise: Admission, Transfer and Discharge

Report reference: Page 68-69

Area(s) of non-compliance		Plan required	Specific	Measureable	Achievable / Realistic	Time-bound
20. The discharge policy did not include the procedure for the discharge of involuntary patients, 4.2.	*Reoccurring*	*New plan required*	Corrective Action(s): This will be updated in the policy Post-Holder(s) responsible: Dr Aisling Campbell (Clinical Director)	Will be completed within 2 weeks	Achievable	ongoing
			Preventative Action(s): This will be updated in the policy Post-Holder(s) responsible: Dr Aisling Campbell (Clinical Director)	Will be completed within 2 weeks	Achievable	ongoing
21. Audits have been completed on the implementation of and adherence to the admission and discharge policies but not the transfer policy, 4.19.	*New*	*Plan Required*	Corrective Action(s): Audit completed Post-Holder(s) responsible: Michelle Murphy (CNM3)	Completed in May 2018 (98%)	Achievable	Ongoing Next audit due in November
			Preventative Action(s): Audit complete Post-Holder(s) responsible: Michelle Murphy (CNM3)	Completed in May 2018 (98%)	Achievable	Ongoing Next audit due in November 2018

22. Communication with the primary care team, a reference to early warning signs of relapse and risks; was not documented, 34.2. 23. A pre-discharge meeting did not address a current mental state examination, a comprehensive risk assessment and risk management plan, or the resident's informational needs, 35.1. 24. A preliminary discharge summary was not sent to the general practitioner/primary care/CMHT within three days, 38.3. 25. A comprehensive discharge summary was not issued within 14 days, 38.3, b. 26. As there was no discharge summary recorded; the following discharge information was not recorded either: details of the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse, 38.4. 27. There was no documented record of the resident's family member, carer, or advocate involved in the discharge process, where appropriate, 39.1.	*New*	*Please provide a detailed plan on how the service intends to address the findings in relation to discharge processes in the approved centre*	Corrective Action(s): Discharge summary to be reviewed and consider updates/changes Post-Holder(s) responsible: Dr Aisling Campbell (Clinical Director)	Discharge audit to be completed in October 2018	Achievable	Ongoing
			Preventative Action(s): Discharge audit to be completed in October 2018 Post-Holder(s) responsible: Karen Reidy (SW) and Dr Eoin Geary (NCHD)	Discharge audit to be completed in October 2018	Achievable	October 2018