Acute Psychiatric Unit, Ennis Hospital

ID Number: AC0022

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Psychiatric Unit, Ennis Hospital
Ennis
Co. Clare

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Maurice Hoare, General Manager, Mid West Mental Health Service

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Martin McMenamin
Noeleen Byrne
Karen McCrohan

Inspection Date:
4 – 7 December 2018

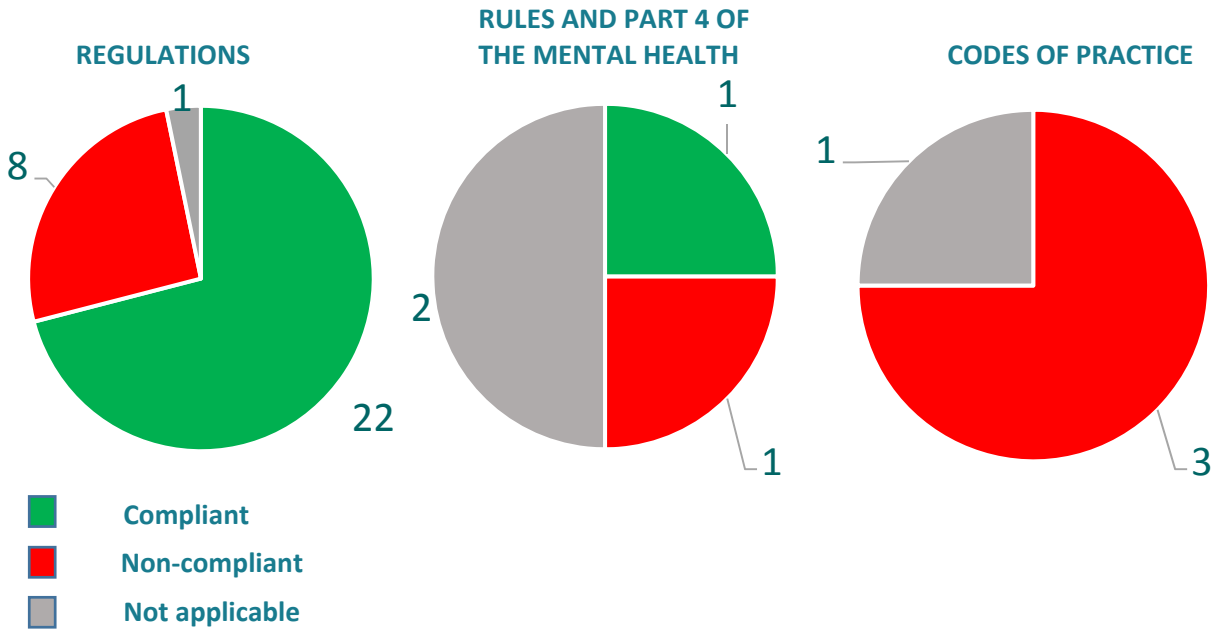
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
29 August– 1 September 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
9 May 2018

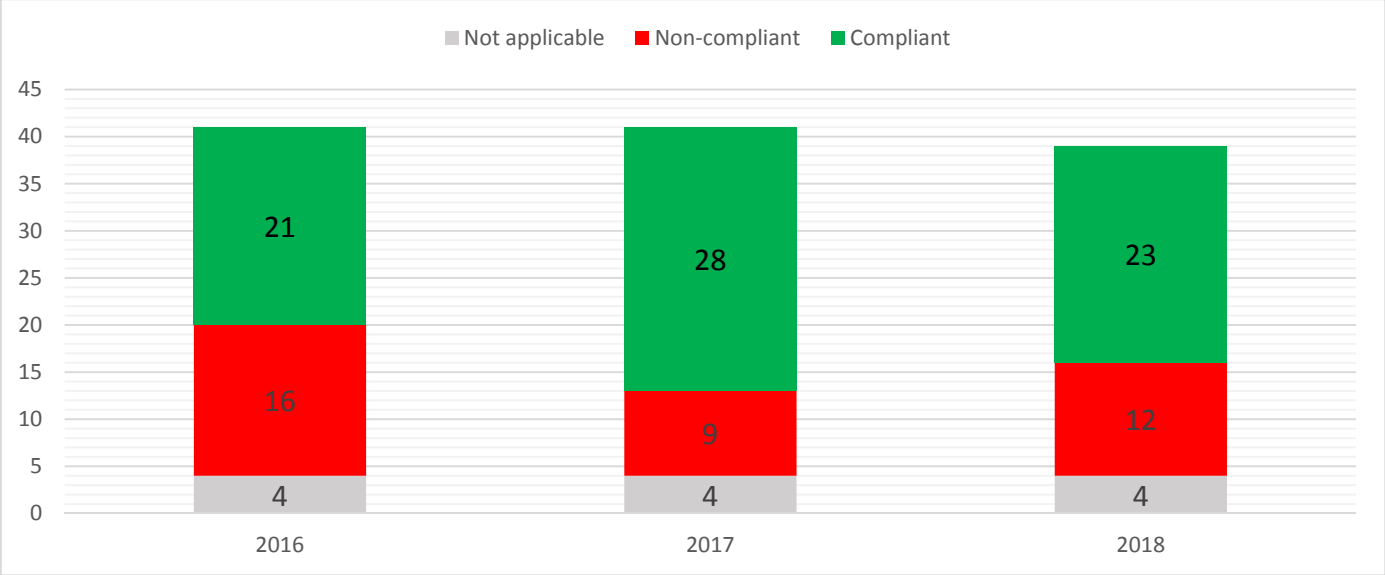
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

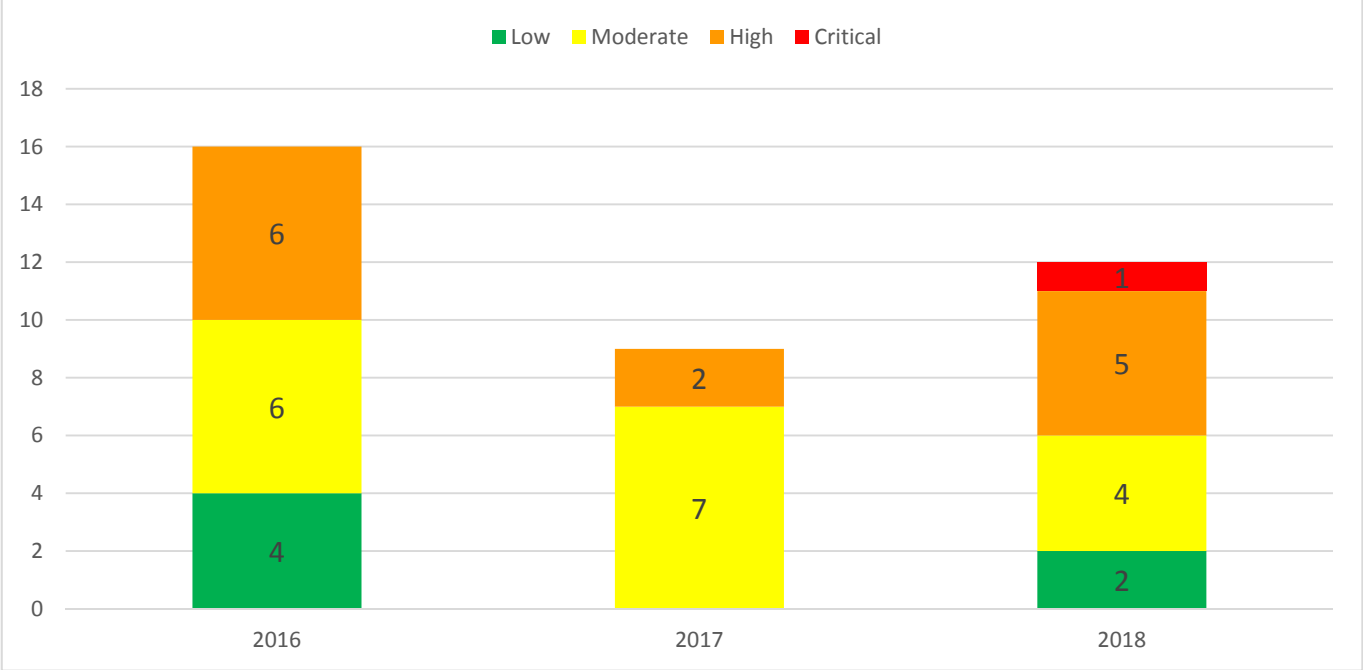
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

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".

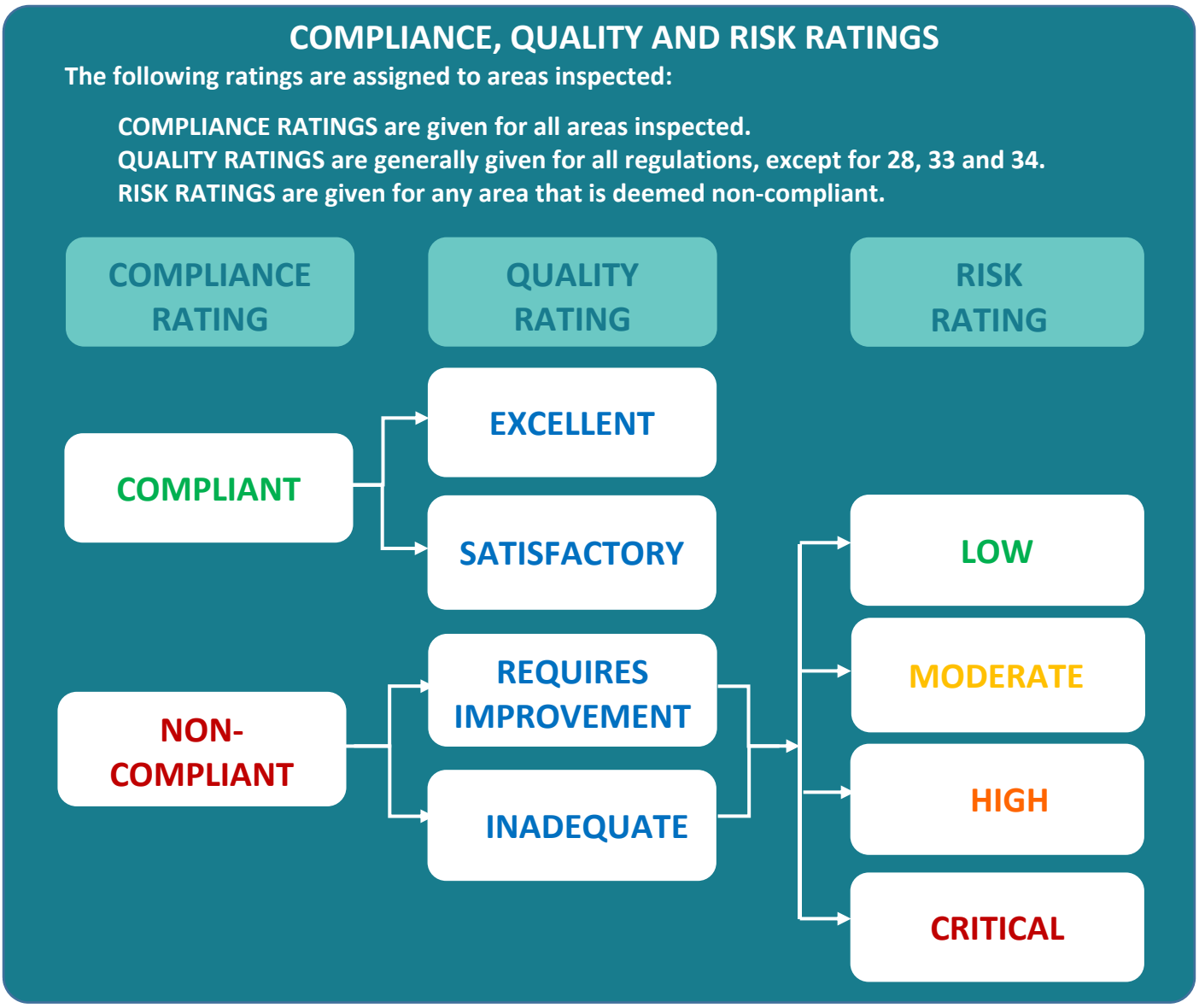
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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 – Review 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 Psychiatric Unit (APU) was located on the ground floor of Ennis Hospital. The 39-bed APU was the acute psychiatric admissions unit for the adult population of Clare and North Tipperary. There were eight consultant led teams admitting to the unit. Thirty-four beds were allocated to general adult admissions and five beds were designated to psychiatry of later life (POLL).

Compliance with regulations, rules and codes of practice has varied over a three year period, from 57% in 2016, 75% in 2017, to 67% in 2018. Regulations on Premises, Staffing, Maintenance of Records and the Rules Governing the Use of Seclusion have been non-compliant for three consecutive years. Four compliances with regulation were rated excellent.

There were two conditions attached to the registration of the approved centre.

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

The approved centre was non-compliant with Regulation 22 Premises on this inspection and for the previous two years, and was non-compliant with Regulation 21 Privacy in 2018.

Condition 2: *To ensure adherence to Regulation 26 (4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

The approved centre was non-compliant with Regulation 26 Staffing on this inspection and for the previous two years.

Safety in the approved centre

Not all health care professionals had up to date training in fire safety, Basic Life Support, management of violence and aggression, or the Mental Health Act 2001. All staff were trained in Children First. Medication management was satisfactory.

The approved centre had commenced works in toilets and shower rooms to minimise ligature points; however, there were still ligature points throughout the approved centre. Some ligature points were not identified within the approved centre's ligature audit. The approved centre was alerted and as a result was planning a re-audit. The risk section of the residents' individual care plans were not always completed.

Appropriate care and treatment of residents

The standard of individual care plans (ICPs) was poor and non-compliance with Regulation 15 Individual Care Plans was risk rated as critical. Goals identified were not adequate to address the resident's needs, the responsibility for implementing the care and treatment required was not always identified, and the resources required to provide the care and treatment were not identified. It was not clear that residents participated in the development of their ICPs. There was no evidence that ICPs were reviewed by the full multi-disciplinary team (MDT). Two MDT meetings had been cancelled in recent weeks and as a result residents did not have a weekly review. It was not clear whether residents were offered a copy of their ICP. Resident feedback during the inspection suggested that not all were invited to attend MDT meetings.

Not all ICPs inspected identified residents' assessed needs and goals regarding therapeutic services and programmes. Residents were not assessed with regard to which therapeutic services and programmes would best suit their needs. However, programmes and services offered in the approved centre were evidence-based and wide-ranging. Therapeutic programmes included Wellness Recovery Action Plans (WRAP), Mindfulness, Advancing Recovery in Ireland Education Service (ARIES), a co-produced workshop with a trained service user, healthy eating programme, baking, pet therapy, art therapy, relaxation class, and self-esteem and a building resilience group. Residents did not have access to psychology. Whilst the occupational therapist (OT) did a one-hour session each week, there was no dedicated OT in the approved centre.

Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as indicated by the residents' needs. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but at least every six months and most essential indices were monitored. However, body mass index (BMI), weight, and waist circumference were not recorded. Residents could access general health services and be referred to other health services. In one case of physical restraint, a registered medical professional did not complete a medical examination within three hours of the end of the episode.

While admission processes were satisfactory, the discharge process was not in accordance with the Code of Practice on Admission, Transfer and Discharge.

Respect for residents' privacy, dignity and autonomy

A Safe Wards Programme had been introduced, which was an evidence-based approach to reducing conflict and containment in approved centres. Residents could meet their visitors in private and could freely use different means of communication, i.e., phone and internet. Residents wore their own clothes and maintained control over their own property.

Clinical files were not in good order, as there were loose pages. The files were not secure, as the logbook of assessments undertaken in the approved centre was stored openly in the reception office and security staff had access to this record. This is a breach of confidentiality.

The observation panel on the seclusion door, which was on the corridor of the high dependency unit, did not have blinds or curtains. Residents were being secluded without compliance with the Rules Governing the Use of Seclusion. In addition, residents were being physically restrained without adherence to the Code of Practice on Physical Restraint.

Responsiveness to residents' needs

The approved entre was not clean, even though there was a cleaning schedule in place. In addition, the approved centre was not in a good state of repair. The painted walls and doors were very badly marked and chipped. Painting had commenced during the inspection. In the care of the elderly unit, the lino in shared dormitories was torn; graffiti was evident on a wall in the high observation unit; a stain was evident on the ceiling of the seclusion room; the garden in the high observation unit required work; the occupational therapy kitchenette's oven and fridge were dirty, and the worktop was chipped; the blinds in the care of the elderly's unit dining room were broken; and one door hinge in the shared dormitory bedroom was badly chipped. Dried paint was evident on the floor in one single bedroom in the high observation unit. Inspectors found that not all faults observed in the approved centre were reported to the maintenance department.

Written information was provided about the approved centre and resident diagnoses and medication and there was a robust complaints procedure in place.

Governance of the approved centre

The APU was a part of the Health Service Executive's (HSE's) Community Healthcare Organisation 3 governance structure, which comprised Clare, Tipperary North and Limerick. Minutes of management team meetings evidenced regular senior management meetings, which addressed issues such as staffing, quality and risk, best practice guidelines and health and wellbeing. There was an organisational chart to identify the leadership and management structures.

Feedback from the heads of discipline, i.e., nursing, occupational therapy, medical staff, psychology and social work, suggested there were clear reporting and escalation structures. They had been trained in risk management, incident reporting, and health and safety. There were systems in place to ensure that risk and incident reporting was escalated appropriately. There were also systems in place to manage the complaints process.

The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy and there was a designated risk manager in place.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of the Safe Wards Programme, which was an evidence-based approach to reducing conflict and containment in approved centres.

2. Introduction of a *Judgement Support Framework* Forum, the focus being to develop quality resources for the approved centre.

3. The introduction of 'hello my name is', an HSE initiative, which is a campaign for more compassionate care within hospital settings.

4. The introduction of a group called Advancing Recovery in Ireland Education Service 'ARIES' which focuses on recovery and well-being education in mental health.

5. The introduction of weekly visits from the Irish Therapy Dogs to the approved centre.

6. A Journal Club (master class) has been established for nursing staff to enable them to critique current research.

7. The introduction of staff meetings in the approved centre to improve communication and share information.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Acute Psychiatric Unit (APU) was located on the ground floor of Ennis Hospital, a short distance from the main hospital entrance. The main reception area of the approved centre had been refurbished since the last inspection and a new assessment room had been built adjacent to the main entrance.

The 39-bed APU was the acute psychiatric admissions unit for the adult population of Clare and North Tipperary. There were eight consultant lead teams admitting to the unit. Thirty-four beds were allocated to general adult admissions. Thirty beds on the main unit comprised of four by four-bedded rooms, three by three-bedded rooms, one by two-bedded rooms and three single rooms. The unit had a four-bed high observation area plus a seclusion room. Five beds were designated to psychiatry of later life (POLL) which comprised of two by two bedded rooms and one single room.

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

Resident Profile	
Number of registered beds	**39**
Total number of residents	**25**
Number of detained patients	4
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	3
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 21: Privacy* and *Regulation 22: Premises*, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.

Condition 2: To ensure adherence to *Regulation 26 (4): Staffing* the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The APU was a part of the Health Service Executive's (HSE's) Community Healthcare Organisation 3 governance structure, which comprised Clare, Tipperary North and Limerick. The inspection team were provided with the minutes of various committees governing the APU, including the Mid-West Clare/North Tipperary Mental Health Services Management Team and the Quality, Patient Safety and Risk Group. Minutes of management team meetings evidenced regular senior management meetings, which addressed issues such as staffing, quality and risk, best practice guidelines and health and wellbeing. There was an organisational chart to identify the leadership and management structures.

Feedback from the heads of discipline, i.e., nursing, occupational therapy, medical staff, psychology and social work suggested there were clear reporting and escalation structures. Responsibilities were clearly defined and the heads of discipline visited at least weekly but generally more often. They had been trained in risk management, incident reporting, and health and safety.

There were systems in place to ensure that risk and incident reporting was escalated appropriately. There were also systems in place to manage the complaints process.

The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders. All operating policies and procedures required by the regulations were reviewed within three years.

4.5 Use of restrictive practices

The doors to the APU were secured with access via swipe card. The rationale for this restrictive practice was to ensure the safety and welfare of the residents. There were no other restrictive practices identified during the inspection process.

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 15: Individual Care Plan	✓		✓		✗	Critical
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	High
Regulation 18: Transfer of Residents	✗	High	✓		✗	Low
Regulation 19: General Health	✓		✓		✗	Moderate
Regulation 21: Privacy	✗	High	✓		✗	Low
Regulation 22: Premises	✗	High	✗	Moderate	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	High
Regulation 27: Maintenance of Records	✗	Low	✗	Moderate	✗	High
Rules Governing the Use of Seclusion	✗	Moderate	✗	Moderate	✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✗	High	✗	High
Code of Practice Relating to the Admission of Children	✗	Moderate	✗	Moderate	✗	Moderate
Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	High	✗	High	✗	Moderate

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

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 10: Religion

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, 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 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) were contacted regarding 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 four residents and five service user experience questionnaires were completed and returned to the inspection team. Residents were generally happy with the care and treatment offered in the approved centre. Some residents mentioned that staff did not always interact with them. Residents reported being involved in setting goals for their individual care plans; however, they were not invited to the multi-disciplinary team meetings. There was good feedback with regard to the food and the food choices. Residents reported feeling safe in the approved centre.

The inspection team met with the IAN representative for the approved centre to discuss issues as reported by the residents. Feedback suggested that there was very positive feedback with regard to the food, nurses, doctors, the activation nurse and the garden area.

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:

- Executive Clinical Director
- General Manager
- Area Director of Nursing
- Assistant Director of Nursing
- Assistant Area Director of Nursing
- Acting Clinical Nurse Manager 3
- Clinical Nurse Manager 2

- Principal Social Worker
- Psychology Manager
- Clinical Psychologist
- Mental Health Act Administrator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Discussion took place regarding a new post for a pharmacist; a business case has been submitted. The CHO 3 are currently developing a new clinical file for use in the approved centre.

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 June 2018. 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 identifying 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: The approved centre used wristbands, addressographs, electronic medical record numbers, names, and dates of birth as resident identifiers, which were appropriate to the resident group profile and individual needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Identifiers were appropriate to the residents' communication abilities and were person specific. A red sticker system alerted staff to the presence of residents with the same, or similar, names.

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

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2018. 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 food and nutrition, as set out in the policy.

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 dietitian approved menus to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, which was presented in an attractive and appealing manner. Residents had at least two meal choices, including daily hot meals. Residents had access to safe, fresh drinking water and hot and cold drinks were provided.

For residents with special dietary needs, their needs were assessed and addressed in residents' individual care plans, if needed. These needs were regularly reviewed by a dietician. Residents and their representatives were educated about resident diets and their interaction with medication. An evidence-based nutrition assessment tool was used, and intake and output charts were maintained where appropriate.

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 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(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 did not have a written policy in relation to food safety.

Training and Education: There was no policy for staff to read, understand, or articulate. Relevant staff interviewed were able to articulate the processes for food safety. 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 recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Food was prepared in a manner that reduced risk of contamination, spoilage, and infection. Hygiene was maintained to support food safety requirements. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Appropriate protective and catering equipment was used during the catering process. Appropriate hand-washing areas were provided for catering services. Residents were provided with crockery and cutlery that addressed their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

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 June 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 monitored on an ongoing basis. This was documented. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents had an adequate supply of individualised clothing, which were clean and appropriate to their needs. The supply of emergency clothing was appropriate and took account of resident preferences, dignity, bodily integrity, religious, and cultural practices. Residents change out of nightclothes during daytime hours unless specified otherwise in their ICPs.

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

Regulation 8: Residents' Personal Property and Possessions

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 September 2018. 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 interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were 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 were entitled to bring personal possessions to the approved centre. Resident property checklists were compiled on admission and updated as needed. Checklists were kept separate from residents' individual care plans (ICP) and were available to residents. Where the approved centre assumed responsibility for a resident's personal property and possessions, they were safeguarded appropriately. Secure facilities were provided for the safekeeping of the residents' personal property.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Access to, and use of, resident monies was overseen by two staff members and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained and where possible counter-signed by the resident or their representative.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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 October 2018. The policy addressed requirements of the *Judgement Support Framework*, but did not identify the facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to 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 recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake and 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. Activities were provided throughout the week, with indoor and outdoor exercise opportunities provided. Activities were provided five days a week and every second weekend. On alternate weekends, activities were provided by nursing staff, if staffing levels permitted. Activities included books, TV, DVDs, board games, and baking. Residents also had access to swimming, outings to the cinema, gardening, and walking groups. The recreational activities were appropriately resourced. Communal areas were provided that were suitable for recreational activities.

Information was provided to residents on the types and frequency of activities in an accessible format. Individual risk assessments were completed to help select appropriate activities. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. Residents were given surveys to complete regarding their likes and dislikes. Recreational activities were also discussed at community meetings. Residents were free to choose whether to participate and their decisions were respected and documented. Logs of participation were maintained for recreational activities.

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 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 March 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. Facilities were provided within the approved centre for residents' religious practices and residents were supported to attend local religious services, if appropriate. This included a chapel in the main hospital, and a chaplain attended the unit every Sunday, for residents who could not attend mass. Residents also had access to multi-faith chaplains. Care and services were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. 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 and procedures in relation to visits, which was last reviewed in June 2018. The policy and procedures addressed requirements of the *Judgement Support Framework*, but did not outline the required visitor identification methods.

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 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: Visiting times were appropriate and reasonable, and were publicly displayed. The unit had a designated family room for visiting, which was a multi-functional room and was utilised for activities during the day. Other communal areas could also be utilised for visits. The visiting areas were suitable for visiting children. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly.

Restrictions on visiting individual residents were justified and documented in clinical files where appropriate. There were restrictions in place at the time of inspection; however, not all staff interviewed were aware of the restrictions. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

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 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 and procedures in relation to resident communication, which was last reviewed in April 2017. The policy and procedures addressed requirements of the *Judgement Support Framework*, but did not outline the assessment of resident communication needs.

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: Residents have access to mail, fax, e-mail, internet, telephone, unless otherwise risk-assessed. Individual risk assessments were completed and documented in relation to any risks associated with their external communication.

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 **Satisfactory**

(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 and procedures in relation to the implementation of resident searches, which was last reviewed in June 2018. The policy and procedures addressed requirements of the *Judgement Support Framework*, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she 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.

The policy did not outline the processes for communicating the approved centre's search policies and procedures to residents and staff.

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 searching processes, 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: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The resident search policy and procedure was communicated to all residents. The clinical file of one resident that was searched was inspected. Risk was assessed prior to a search of a resident or their property. Resident consent was sought prior to all

searches, which was documented. Staff informed the resident of what was happening during a search and why. Policy requirements were implemented when illicit substances were found.

At least two clinical staff were in attendance at all times when the search was conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of the search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who attended the search.

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 14: Care of the Dying

COMPLIANT

(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 and protocols in relation to care of the dying, which was last reviewed in April 2018. The policy and protocols addressed requirements of the *Judgement Support Framework*, but did not outline 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: 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.

There had been no deaths in the approved centre since the last inspection, the approved centre was assessed under the two pillars of processes and training and education.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

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 June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: 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 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: Twelve ICPs were reviewed on inspection. Each resident was initially assessed at admission and an ICP was completed to address his or her immediate needs. Four ICPs were not developed by the MDT following a comprehensive assessment, within seven days of admission. The comprehensive assessment included appropriate information and assessments.

Each ICP was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. ICPs identified residents' goals, treatment, and care. However:

- In five ICPs, inspected goals identified were not adequate to address the resident's needs.
- The responsibility for implementing the care and treatment required was not always identified.
- In six of the 12 ICPs, the resources required to provide the care and treatment were not identified.

ICPs included a preliminary discharge plan, where deemed appropriate, and a risk management plan. A key worker was identified to ensure continuity in the implementation of each ICP. It was not clear that residents participated in the drawing up of their ICPs. Evidence-based assessments were used where possible.

There was no evidence that ICPs were reviewed by the full MDT. Two MDT meetings had been cancelled in recent weeks and as a result, residents did not have a weekly review. ICPs were updated following review and residents were kept informed of any changes. It was not clear whether residents were offered a copy of their ICP. Resident feedback during the inspection suggested that not all were invited to attend MDT meetings.

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

a) **Not all ICPs were developed, regularly reviewed or updated by the MDT.**
b) **The goals identified were not always adequate to address the resident's needs.**
c) **Not all ICPs identified the care and treatment required to meet the goals identified.**
d) **The resources required to provide the resident's care and treatment were not identified in the ICPs.**
e) **Residents were not always involved in the development and review of their ICPs.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

Training and Education: 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 not 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: Not all ICPs inspected identified resident's assessed needs and goals regarding therapeutic services and programmes. Residents were not assessed with regard to which therapeutic services and programmes would best suit their needs. Programmes and services offered by the approved centre were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Programmes and services offered in the approved centre were evidence-based. Therapeutic programmes included Wellness Recovery Action Plans (WRAP), Mindfulness, Advancing Recovery in Ireland Education Service (ARIES), a co-produced workshop with a trained service user, healthy eating programme, baking, pet therapy, art therapy, relaxation class, and self-esteem and a building resilience group. The occupational therapists (OT) did a group once a week, as did social work, and the approved centre ensured there were three groups a day. Residents did not have access to psychology. Whilst the OT's did a one-hour session each week, there was no dedicated OT in the approved centre. This resulted in the residents not being able to access an appropriate range of therapeutic services and programmes.

Adequate and appropriate resources and facilities were available, and were provided in a separate dedicated room containing facilities and space for individual and group therapies. Where no internal service existed, an appropriate external service with an approved, qualified health professional was found. A list of services and programmes provided in the approved centre was available to residents. A record was maintained of participation, engagement, and outcomes achieved through the therapeutic programme in residents' ICPs or clinical files.

The approved centre was non-compliant with this regulation because residents did not have access to psychology and occupational therapy and as a result they were unable to access an appropriate range of therapeutic services and programmes, 16 (1).

Regulation 18: Transfer of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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, which was last reviewed in February 2018. 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 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: One file was reviewed on inspection. Verbal communication and liaison took place between the approved centre and the receiving facility prior to transfers, and included a discussion of the reasons for transfer and the resident's accompaniment requirements. However, a risk assessment had not been completed prior to the resident being transferred. The information accompanied the resident upon transfer, which included a letter of referral, medication requirements, and a transfer form. There was no evidence that a checklist was completed by the approved centre to ensure comprehensive resident records were transferred.

Documented consent from the resident was available, or justification as to why consent was not received. Communication records with the receiving facility were documented and available on inspection. Copies of all records relevant to the resident transfer were retained in the resident's clinical file.

The approved centre was non-compliant with this regulation because not all relevant information about the resident was provided to the receiving facility, 18 (1).

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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:

- Policy on General Health and Physical Health care, which was last reviewed in October 2018.
- Policy and Procedure for responding to Medical Emergencies, which was last reviewed in August 2017.

The policies and procedures 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 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 had been undertaken 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: 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 on an ongoing basis as indicated by the residents' needs. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but at least every six months. The six-monthly general health assessment included a physical examination, and assessed family and personal history, blood pressure, smoking and nutritional status, and a medication and dental review. However, body mass index (BMI), weight, and waist circumference were not recorded.

Residents on antipsychotic medication received an annual assessment that measured their blood lipid levels. However, prolactin levels were not measured. Two residents had refused examination and this was recorded. Attempts were made to re-examine and undertake bloods at a later date.

Residents could access general health services and be referred to other health services. Procedures for access to general health services were outlined and residents accessed secondary services by referral. Residents had access to national screening programmes where available and applicable to the resident. There was a localised policy on tobacco use and residents were supported to stop smoking.

Residents' completed general health checks and associated results were recorded. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator. Both were checked weekly.

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

a) **Six-monthly general health assessments did not include BMI, weight or waist circumferences, 19 (1)(b).**
b) **Annual assessments of prolactin levels had not been completed for residents on antipsychotic medication, 19 (1)(b).**

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 policy and procedures in relation to the provision of information to residents, which was last reviewed in June 2018. The policy and procedures addressed requirements of the *Judgement Support Framework*, but did not outline the methods for providing information to residents with specific communication needs.

Training and Education: 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: An information booklet was provided to residents and their representatives at admission in the required format. The booklet was clearly and simply written, and outlined the required information on care, services, and housekeeping practices, including arrangements for personal property, mealtimes, visiting times, and visiting arrangements, the complaints procedure, relevant advocacy and voluntary agencies, residents' rights, and details of the multi-disciplinary team.

A variety of diagnosis and medication-related information, including risks and potential side effects, was available and provided to residents as appropriate. Information included evidence-based information about diagnosis, unless the provision of such information would be detrimental to a resident's health and well-being. The justification for restricting information was documented. Evidence-based websites were used to obtain information for residents. Information was accessible and residents had access to interpretation and translation services as required. Documentation was appropriately reviewed and approved prior to implementation.

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 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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 June 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.
- The approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

Training and Education: 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: Staff had an appropriate demeanour and dressed appropriately. Staff communicated with residents appropriately, used discretion when discussing medical conditions or treatment, and used residents' preferred names. Staff sought the resident's permission before entering their room. Bathrooms, showers, toilets, and single bedrooms had locks with an override function. All residents were wearing clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls. Residents were permitted to retain their mobile phones, unless a risk was identified. Residents could also utilise the approved centre's portable phone.

Where residents shared a room, the bed screening ensured that their privacy was not compromised. The observation panel on the seclusion door, which was on the corridor of the high dependency unit, did not have blinds or curtains. Rooms that were overlooked by public areas had opaque glass. Noticeboards did not display resident names or other identifiable information.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times, as the observation panel on the seclusion door did not have blinds or curtains.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 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 could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. However, not all ligature points observed on the walkabout were identified within the AC's ligature audit. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and room to move about. The approved centre did not provide suitable furnishings to support resident independence and comfort. Three of the four wardrobes in one shared dormitory were badly stained. The chair coverings, within one sitting room, were torn. There were suitable furnishings and supports to assist resident independence and comfort. There were enough toilets and showers, which were appropriately placed. However, the accessible toilets were not clearly marked. There was a sluice room, cleaning room, and dedicated therapy room. The approved centre did not have a laundry room. Storage was limited in the approved centre, for example, hoists were stored in the corridor of the care of the elderly unit.

No excessive noise was noted in the approved centre. Rooms were well heated and ventilated. A new ventilation system was installed in the approved centre last year. Despite the new ventilation system, the shower room (in particular) in the shared dormitory in the high observation unit was malodorous. Heating could be changed in individual resident rooms. The lighting in some communal rooms was observed to be

very poor. Only a limited number of rooms had appropriate signage, as a result resident's orientation needs were not facilitated. The approved had plans to address this.

Ligature points were not minimised to the lowest practicable level, based on risk assessment. The approved centre had completed work to minimise ligature points last year. However, ligature points remained, including window blind brackets, fixed toilet paper/hand towel holders, doors handles and hinges, windows and sinks in shared dormitories. Some of these ligature points were not identified within the approved centre's ligature audit. The approved centre was alerted and as a result was planning a re-audit. Staff noted that identified ligatures points were mitigated through active risk management i.e. increased observation.

The approved centre was not in a good state of repair. The painted walls and doors were very badly marked and chipped. However, painting had commenced during the inspection - all internal walls and doors were to be painted. In the care of the elderly unit, the lino in shared dormitories was torn (this was due to be addressed in December 2018). Graffiti was evident on a wall, in the high observation unit (this was addressed during the inspection). A coffee stain was evident on the ceiling of the seclusion room. The garden in the high observation unit required work; the approved centre had submitted a business plan to redesign the garden, as well as the care of the elderly unit's courtyard. The occupational therapy kitchenette's oven and fridge were dirty, and the worktop was chipped (the kitchenette was cleaned during the inspection). The blinds in the care of the elderly's unit dining room were broken. One door hinge in the shared dormitory bedroom was badly chipped. Dried paint was evident on the floor in one single bedroom in the high observation unit. It was noted that not all faults observed in the approved centre were reported to the maintenance department.

There was a regular programme of general maintenance. Maintenance and faults were recorded and communicated appropriately. The approved centre had access to back-up power. Hazards were appropriately identified and minimised. There was a cleaning schedule; however, the approved centre was not clean and hygienic. The shower room, in the shared dormitory within high observation unit, was observed to be malodorous. The maintenance department were aware of the issue pertaining to ventilation. Dirt was evident on the floor of one single bedroom within the high observation unit. This was subsequently cleaned. Current national infection control guidelines were followed.

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

a) **The approved centre was not clean and maintained in good structural and decorative condition, 22(1)(a).**
b) **The approved centre was not adequately lit or ventilated, 22(1)(b).**
c) **The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22 (2).**
d) **Ligature points in the approved centre had not been minimised to the lowest practicable level, 22 (3).**

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

COMPLIANT

Quality Rating **Satisfactory**

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

(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 a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in June 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process applied when medication is refused by the resident.
- The process for medication reconciliation.
- The process for reviewing resident medication.

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

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: Ten MPARs were reviewed on inspection. All entries were legible, written in black, indelible ink, and used two appropriate identifiers. MPARs had dedicated space for routine, once-off, and "as-required" medications. A record of all medications administer to residents was kept, as well as the dose, frequency, administration route, date of initiation and discontinuation, generic and full name, and resident allergies were recorded. Micrograms were written in full. MPARs included the Medical Council Registration Number of every medical practitioner prescribing medication, and MPARs were signed by the medical practitioner after each entry.

All medicines were administered by a registered nurse or medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of medication was checked prior to administration; expired medications were not administered. Good hand-hygiene techniques were implemented during the administering of medications. Schedule 2 controlled drugs were checked by two staff members, including one registered nurse, against the delivery form. Details were entered on the controlled drug book and signed by both staff members. The controlled drug balance corresponded with the balance recorded in the controlled drug book.

When a resident's medication was withheld, the justification was noted in the MPAR and documented in a clinical file. Medication was stored in an appropriate environment. Medication storage areas were clean,

and free from damp, mould, litter, dust, pests, spillage or breakage. Food and drink was not stored in areas used for medication storage. Medication storage areas were incorporated in the cleaning and housekeeping schedules. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

Medication dispensed or supplied to residents was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley and medication administration cupboard were locked at all times and secured in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

Medication was reviewed and rewritten at least six-monthly, or more frequently as appropriate; this was documented in clinical files. Medical practitioners rewrote prescriptions where alteration was required. Neither a system of stock rotation nor an inventory of medications were undertaken. Medications that were no longer required or were past their expiry date were not appropriately stored.

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 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 written operational policies and procedures in relation to the health and safety of residents, staff, and visitors:

- Safety statement, dated March 2018.
- National Standards for the prevention and control of healthcare associated infections policy.
- HSE Policy on needle stick injury.

The policies and the safety statement included all of the requirements of the *Judgement Support Framework*.

Training and Education: 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, which was last reviewed in March 2017. The policy addressed requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre, but did not outline the maintenance of CCTV cameras by the approved centre.

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: There were clear signs in prominent positions where CCTV cameras (or other monitoring systems) were located. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. CCTV cameras were incapable of recording or storing a resident's image. CCTV cameras did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the health and welfare of the resident. The usage of CCTV was disclosed to the Mental Health Commission.

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 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 adopting the HSE National Recruitment service policy. The policy and procedures addressed requirements of the *Judgement Support Framework*, including the following:

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

The policy and procedures did not address the following:

- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- 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.

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: The numbers and skill mix of staffing were not sufficient to meet resident needs, as there was a shortage of psychologists in the approved centre, and residents did not always have access to a psychologist. There was no dedicated OT for the approved centre. Staff were recruited and

vetted in accordance with the approved centre's policy and procedure. Staff had the appropriate qualifications to do their job. The required number of staff were on duty at night to ensure safety of residents in the event of a fire or other emergency. A planned and actual staff rota was maintained and an appropriately qualified staff member was on duty and in charge at all times; this was documented. There was an organisational chart to identify the leadership, management structure, and lines of authority and accountability. Where agency staff were used, there was a comprehensive contract between the approved centre and registered/licensed staffing agency, which set out the vetting requirements for potential staff.

There was a staffing plan for nursing staff only. Other disciplines were not mentioned in the document. Annual staff training plans had been completed to identify required training and skills development. New staff completed orientation and induction training. Not all health care professionals had up to date training in fire safety, Basic Life Support, management of violence and aggression, or the Mental Health Act 2001. All staff were trained in Children First. Staff had also received a range of additional training, including manual handling, infection control and prevention, risk management, dementia care, care for residents with intellectual disability, recovery-centred approaches to mental health care and treatment, incident reporting, and protection of children and vulnerable adults.

Opportunities were made available and communicated to staff, and staff were supported to undertake further education. In-service training was completed by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training.

Staff training was documented and staff training logs were maintained. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

The following is a table of clinical staff assigned to the approved centre:

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM2	2	Shared
	RPN	6	4
	HCA	0	Shared
Main Unit	Activation Nurse (9-5pm)	1	0
	Occupational Therapist	Referral	0
	Social Worker	Referral	0
	Psychologist	Referral	0

HCA shared between the main unit and old age at night.

Ward or Unit	Staff Grade	Day	Night
POLL Unit	RPN	1	1
	HCA	1	Shared
	Occupational Therapist	Referral	0
	Social Worker	Referral	0
	Psychologist	Referral	0

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) **The numbers and skill mix of staffing were not sufficient to meet the resident needs, 26 (2).**
b) **Not all staff were up-to-date with required mandatory training, 26 (4).**

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 written policies and procedures in relation to the maintenance of records:

- Recording Clinical Information, which was last updated April 2017.
- HSE Record Retention Periods 2013.
- HSE Standards and Recommended Practices for Healthcare Records Management.

The policies and procedures addressed requirements of the *Judgement Support Framework*, including the following:

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

The policies and procedures did not address the following:

- Residents' access to resident records.
- The relevant legislative requirements relating to record maintenance; the implementation of the Data Protection Acts, Freedom of Information Acts and associated controls for records.
- The process for making a retrospective entry in residents' records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policies. 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 policies. All clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: The approved centre maintained a record for every resident who was assessed or provided with care. Records had unique identifiers, up to date, and maintained in line with national guidelines and legislative requirements. However, they were not in good order, as there were loose pages. The files were not secure, as the logbook of assessments undertaken in the approved centre was stored openly in the reception office. Security staff had access to this record. Only authorised staff could access data and make new entries, and residents' could access records in line with relevant legislation. Staff had access to the information needed to carry out their job.

Not all records were maintained appropriately. Those inspected were found to be factual, consistent, reflecting the residents' current status, using date and time (using the 24 hour clock), and signed appropriately. However, records were written in pink-coloured ink and were not readable when photocopied. The approved centre also maintained a record of signatures used in resident record. Where errors were made, they were corrected appropriately. Documentation of food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements.

The approved centre was non-compliant with this regulation because records were not maintained in good order, as there were loose pages, nor were they kept in a safe and secure place 27(1).

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

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 adopted the HSE National Framework for developing policies, procedures, protocols, and guidelines. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the development, management, and review of 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 process for making obsolete and retaining previous versions of operating policies and procedures.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all 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 not 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 operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately approved, and communicated to all relevant staff. The policies were not appropriately formatted, as they did not identify the document owner or date at which the policy will be implemented (effective from). Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff.

Generic policies were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre has a written statement adopting the generic policy.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

(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, which was last reviewed in September 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 not 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 Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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

Regulation 31: Complaints 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 relation to the management of complaints, which was last reviewed in April 2016. The approved centre also adopted the HSE's National Policy on Complaints *Your Service Your Say* (2015 version). The policies and procedures addressed 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. The policies and procedures did not address the following:

- The roles and responsibilities associated with the management of complaints within the approved centre, including a nominated person responsible to deal with all complaints.
- The documentation of complaints, including the maintenance of a complaints log by the nominated person.

Training and Education: Relevant staff had been trained on the complaints management process. 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 for making, handling, and investigating complaints, as set out in the policies.

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. Most complaints were received via the *Your Service Your Say* feedback box or verbal complaints. There were also community meetings every two weeks where issues of concern are raised and documented. Residents and their representatives

were assisted to make complaints using appropriate methods and were facilitated to access an advocate. There was a nominated complaints officer who was responsible for dealing with complaints, who was clearly identified. There was also a method for addressing minor complaints. The approved centre had a local complaints log. They were noted in the community minutes, held fortnightly. Record of outcomes was also observed. The complaints officer dealt with minor complaints that could not be addressed locally.

All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes, and the complainant's view of the outcome. This was kept distinct from the resident's individual care plan.

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 information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

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 process pillar.

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 written policies in relation to risk management and incident management procedures:

- HSE Integrated Risk Management Policy.
- Addendum to the HSE Integrated Risk Management Policy and Supporting Guidance 2017 and the Incident Management Framework 2018 for the Mental Health Division in HSE Mid-West Community Healthcare, which was last reviewed in 21 March 2018.
- Local manual for management of serious incidences and serious reportable events, which was last reviewed in April 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 of identification, assessment, treatment, reporting, and monitoring of ligature points throughout the approved centre.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. 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 reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical, corporate, and health and safety risks were identified, assessed, monitored, and documented in risk registers. The approved centre had commenced works in toilets and shower rooms to minimise ligatures, however, there were still ligature points throughout the approved centre. Staff stated that remaining ligatures points were mitigated through active risk management i.e. increased staffing and observation. A plan was implemented to reduce risks to residents while works to the premises were ongoing. The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes.

Individual risk assessments were completed prior to and during resident seclusion and physical restraint, and in conjunction with medication requirements or administration. However, they were not undertaken for resident on admission, transfer or discharge. The risk section of the resident's individual care plans were not always completed.

Incidents were recorded and risk-rated in a standardised format. The designated risk manager reviewed incidents for any trends or patterns occurring in the services, and clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of reviews and recommended actions. The Mental Health Commission was provided with a six-monthly summary report of all incidents, with information anonymised at a resident level.

The requirements for the protection of children and vulnerable adults were appropriate and implemented. There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures.

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

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

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 with two conditions to registration attached. The certificate was displayed prominently.

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)

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating **HIGH**

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to the use of seclusion, the training of staff in relation to the use of seclusion, and the use of CCTV for observing residents in seclusion, which was last reviewed in September 2018. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Three episodes of seclusion were reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests, when the resident posed immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner or nurse. A consultant psychiatrist was notified as soon as practicable of the use of seclusion. Seclusion orders did not last longer than eight hours. In no case were residents informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion. The reason for this was not documented in a clinical file. In no case were the residents informed of the ending of an episode of seclusion; nor was this recorded. Cultural awareness and gender sensitivity was demonstrated. Residents' clothing and searches respected their right to dignity, bodily integrity, and privacy. Security staff were noted to have assisted in seclusion (as per the seclusion form). Security staff member did not have up-to-date PMVA training.

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of the seclusion episode was made by

a nurse every 15 minutes, including level of distress and behaviour. A medical review of the patient was undertaken no later than four hours after the commencement of the episode of seclusion. However, in one case the resident was not then reviewed every four hours.

The seclusion initiation was recorded in a clinical file and seclusion register by the person who initiated seclusion. In one case, the responsible consultant psychiatrist did not enter a date beside their signature, so it is unable to be determined if they had signed the seclusion register within 24 hours. In one case, the resident's representative was not informed, and the reason for this was not recorded in a clinical file. The reason for ending seclusion was recorded in clinical files. A copy of the seclusion register was placed in the clinical file. In two cases, the episode of seclusion was not reviewed by members of the multi-disciplinary team and documented in clinical file within two working days.

Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. Toilet and washing facilities were available adjacent to the seclusion room. All furniture and fittings were of a design and quality so as not to endanger patient safety. The seclusion room was not used as a bedroom.

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

a) **In one case, the responsible consultant psychiatrist did not enter a date beside their signature, making it difficult to determine if they had signed the seclusion register within 24 hours, 3.5.**
b) **In no case were residents informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion. The reason for this was not documented in a clinical file, 3.6.**
c) **In one case, the resident's representative was not informed, and the reason for this was not recorded in a clinical file, 3.7(a).**
d) **In one case, the resident was not medically reviewed every four hours, 5.4.**
e) **In no case were the residents informed of the ending of an episode of seclusion; nor was this recorded, 7.3 and 7.4.**
f) **In two cases, the episode of seclusion was not reviewed by members of the multi-disciplinary team and documented in clinical file within two working days, 10.3.**

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 files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In both cases, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment, or equivalent, following administration of medication for a continuous period of three months. In both cases, a *Form 17: Administration of Medicine for more than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the other resident, which contained:

- The name of the medication(s) prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of discussion with patient, including the nature, purpose, effects of the medication(s).
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Any views expressed by the patient.
- The approval and authorisation of two consultant psychiatrists.

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

Quality Rating Requires Improvement
Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated September 2018. It addressed the following:

- The provision of information to the resident
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: Three episodes of physical restraint were reviewed on inspection. In all cases, physical restraint was used in rare, exceptional circumstances, and in the best interests of the resident. Physical restraint was only exercised where a resident posed immediate threat of serious harm to self or others, after all alternative interventions had been considered, and based on a risk assessment. Orders for physical restraint did not last for longer than 30 minutes. In one case, there was no evidence that the resident was informed of reasons for, likely duration of, or circumstances leading to discontinuation. The reason for this was not documented in the clinical file.

Physical restraint was initiated by an appropriate health professional in line with the physical restraint policy. A designated staff member was responsible for leading the physical restraint and monitoring the head and airway of the resident. In one case, the consultant psychiatrist or duty consultant psychiatrist was not notified as soon as was practicable. Cultural awareness and gender sensitivity was demonstrated. A same sex staff member was present at all times during physical restraint where practicable. Staff were aware of relevant considerations in individual care plans.

In one case, a registered medical professional did not complete a medical examination within three hours of the end of the episode. As soon as practicable and with resident's consent, or where resident lacked capacity and could not consent, the resident's representative was informed of the use of physical restraint; this was recorded. Where the representative was not informed, this was justified and recorded.

Each episode of physical restraint was documented in the clinical files. A clinical practice form was completed by the initiator of physical restraint within three hours. In one case, that form was not signed by a clinical psychiatrist within 24 hours and placed into the resident's clinical file. In one case, the resident did not have the opportunity to discuss the episode with members of the multi-disciplinary team (MDT). In one case, the episode was not reviewed by members of the MDT and documented within two working days.

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

a) **In one case, the consultant psychiatrist or duty consultant psychiatrist was not notified as soon as was practicable, 5.3.**
b) **In one case, a registered medical professional did not complete a medical examination within three hours of the end of the episode, 5.4.**
c) **In one case, that form was not signed by a clinical psychiatrist within 24 hours, 5.7(c).**
d) **In one case, there was no evidence that the resident was informed of reasons for, likely duration of, or circumstances leading to discontinuation. The reason for this was not documented in the clinical file, 5.8.**
e) **In one case, the resident did not have the opportunity to discuss the episode with members of the multi-disciplinary team, 7.2.**
f) **In one case, the episode was not reviewed by members of the multi-disciplinary team and documented within two working days.**

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 written policy in relation to the admission of a child, which was last reviewed in February 2017. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

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

Evidence of Implementation: Age-appropriate facilities and a programme of activities were not provided by the approved centre. Provisions were in in place to ensure the safety of the child, respond to child's special needs as a young person in an adult setting, and to ensure the right of the child to have his/her views heard.

Children had their rights explained and information about the ward and facilities provided in an understandable way; however, this was not recorded. Consent for treatment was obtained from one or both parents.

Appropriate visiting arrangements and accommodation was provided. Observation arrangements, including assignment of designated staff member, was provided as considered clinically appropriate and respected gender sensitivity.

Advice from the Child and Adolescent Mental Health Service was available. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. The Mental Health Commission was notified of children admitted to the approved centre for adults within 72 hours of admission using the associated notification form. Staff having contact with the child had undergone Garda vetting.

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

a) **Age-appropriate facilities and a programme of activities were not provided by the approved centre, 2.5(b).**
b) **The approved centre did not record the child's understanding of their rights and information about the wards and facilities, 2.5(h).**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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. They were last reviewed in February 2018. The policies included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: All admissions were on the basis of mental illness or mental disorder. Residents received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, and any other relevant information such as work situation, education, and dietary requirements. However, assessments did not include a risk assessment. The resident received a full physical examination. A key worker system was in place.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: The approved centre maintained discharge plans, which included documented communication with relevant health professionals, an estimated date of discharge, and a follow-up plan. However, they did not include references to early warning signs of relapse and risk.

Discharge meetings were attended by residents and their representatives, key worker, and relevant members of multi-disciplinary team. Discharge assessments addressed psychological and psychiatric needs, but did not include a current mental state examination, comprehensive risk assessment and risk management plan, or informational needs. Discharges were coordinated by a key worker.

There was no evidence that preliminary discharge summaries were sent to the appropriate health practitioner within three days; nor was there evidence that comprehensive discharge summaries were issued within 14 days. There was no evidence that resident representatives were involved in discharge process. A timely follow-up appointment was made.

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

a) **Admission assessments did not include a risk assessment, 15.3.**
b) **The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.**
c) **Discharge plans did not did not include references to early warning signs of relapse and risk, 34.2.**

d) **Discharge assessments did not include a current mental state examination, a comprehensive risk assessment and risk management plan, or informational needs, 34.4.**
e) **There was no evidence that preliminary discharge summaries were sent to the appropriate health practitioner within three days, 38.3.**
f) **There was no evidence that comprehensive discharge summaries were issued within 14 days, 38.3(b).**
g) **There was no evidence that resident representatives were involved in discharge process, 39.1.**

Appendix 1: Corrective and Preventative Action Plan Template – APU Ennis - 2018 Inspection Report

Regulation 15: Individual Care Plan

Report reference: Pages 30 & 31

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. Not all ICPs were developed, regularly reviewed or updated by the MDT	*New*	Corrective Action(s): All ICPs on unit have been reviewed by the mdt. As of 01/01/2019 full MDT involvement is captured in the ICP and they are regularly reviewed and updated Post-Holder(s) responsible:MDT of each resident	Audit /Analysis and Action Plan	Achieved	Completed
		Preventative Action(s): Updated audit tool/ audits weekly/ memo sent from Clinical Director and CNM3 to all MDT staff. All staff have signed to say that they have read and understood the policy. Workshops available for all staff on ICP guidance document MHC. Post-Holder(s) responsible:Clinical Director and CNM3.	Weekly audit Training dates circulated	Achievable and in progress	Immediate
2. The goals identified were not always adequate to address the resident's needs.	*New*	Corrective Action(s): Goals now identified on all ICPs as of February 2019. These goals are recovery focused and specific, Post-Holder(s) responsible:All mdt staff and CNM3.	Audit and analysis, weekly	Achieved	completed
		Preventative Action(s): New ICP template in development, New audit tool available, training on ICPS commenced Post-Holder(s) responsible: ICP Development committee/ CNM3, CNM2 / A/ADON	Records of training retained . Analysis on training to be completed	Achievable and in progress	6 months for new template

3. Not all ICPs identified the care and treatment required to meet the goals identified. 4. The resources required to provide the resident's care and treatment were not identified in the ICPs	*New*	Corrective Action(s): MEMO sent by clinical director to all medical staff, all heads of disciplines informed. Post-Holder(s) responsible: Clinical Director and CNM3.	Audit on ICPS weekly	Achieved and ongoing	Completed and ongoing
		Preventative Action(s): Training and workshops offered to all staff/ MHC guidance document to be provided to staff Post-Holder(s) responsible: CNM2, CNM3 and A/ADON	Records of training retained . Analysis on training to be completed	Achievable and realistic	3 months for all training
5. Residents were not always involved in the development and review of their ICPs	*New*	Corrective Action(s):Resident involvement now discussed in detail throughout care plan presentation and training. New leaflet on care planning to be developed for residents Post-Holder(s) responsible: CNM3, CNM2 and A/ADON	Minutes of community meetings . Audit and analysis to capture resident involvement. Feedback from training	Achievable and realistic	3 months
		Preventative Action(s): Training for staff Discussion with resident s on ICPs at community meetings. ICPs workshops if staff require Open door policy with CNM3 in relation to care planning Post-Holder(s) responsible: CNM3 on unit.	To achieve 100% in training records	Achievable and in progress	3 months

Regulation 16: Therapeutic Services and Programmes

Report reference: Page 32

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
6. Residents did not have access to psychology and occupational therapy and as a result they were unable to access an appropriate range of therapeutic services and programmes, 16 (1).	*New*	Corrective Action(s): New 0.5 OT now recruited for the approved centre.Due to commence in May. Email sent by CNM3 to arrange a meeting in relation to psychology for the APU. Psychology input to be discussed with Head of Psychology and all psychologists on Mental Health Teams and Activation nurse. Meeting to be held in relation to Findings of report in relation to psychology input and actions to commence. A new leaflet to be developed for residents in relation to therapeutic services and programmes. Post-Holder(s) responsible Head of Psychology, Clinical Director, ADON Acute Unit, CNM3 and A/ADON	Audit on Therapeutic Services and programmes completed To complete weekly analysis on therapeutic services and programmes to ensure it meets assessed needs. Minutes of meetings to be documented in relation to psychology input to the approved centre	Achievable and in progress	6 months
		Preventative Action(s): All staff have signed to say that they have read and understood the policy. Training has commenced on ICPS which incorporates Reg 16	Analysis on regulation 16 to ensure the services provided are meeting the assessed needs of the residents	Achievable and in progress	6 months

		Therapeutic Services and programmes. New Psychology informed groups to commence on Unit. Immediate meeting with psychology planned to address any deficits. Post-Holder(s) responsible: A/ADON will do training. Clinical Director ADON APU. Head of psychology to discuss findings on regulation 16 with all psychologists on Mental Health teams.			

Regulation 18: Transfer of Residents

Report reference: Page 33

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
7. Not all relevant information about the resident was provided to the receiving facility, 18 (1).	*New*	Corrective Action(s): All transfers are completed in accordance with Regulation 18 and the code of practice on discharge.	Transfer s now meet the regulation and code. Audit monthly to be completed to ensure compliance	Achieved	Completed
		Preventative Action(s): All staff have signed to say that they have read and understood the policy. New transfer checklist/ pro forma completed that meets all of the requirements of the regulation and the code of practice. Post-Holder(s) responsible: CNM3 of unit.	On going training on Transfer of residents	Achieved	Completed checklist/proforma in place. Training to take place over the next 4 months

Regulation 19: General Health

Report reference: Pages 34 & 35

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
8. Six monthly general health assessments did not include BMI, weight or waist circumferences, 19(1)(b).	*New*	Corrective Action(s): All six monthly generl health assessments are completed and up to date Post-Holder(s) responsible: Mental Health Teams consultants and SHO	Audit and analysis completed	Achieved	Completed
		Preventative Action(s): New Template completed and available to medical personnel, will meet requirements, once completed in full. Post-Holder(s) responsible: CNM3	Audit and analysis	Achieved	New template/proforma now completed
9. Annual assessments of prolactin levels had not been completed for residents on antipsychotic-medication, 19(1)(b).	*New*	Corrective Action(s): All prolactin levels have been completed for residents over 6 months in the approved centre. Systematic review in place to indicate when six monthly medical assessments are due. Clinical Director to provide Informational session on new template and regulation 19 to all current and new medical personnel. Post-Holder(s) responsible: Clinical Director and all medical personnel	Ongoing audit and analysis Ongoing training on new template and policy	Realistic and in progress Achievable and in progress	completed

		on each Mental Health Team working within APU.			
		Preventative Action(s): All staff have signed to say that they have read and understood the policy. On going training/ New template/ Informational sessions. All staff provided with workshop Post-Holder(s) responsible: Clinical Director/ CNM3/ ADON	Feedback from staff/ Documentation of staff trained	Achievable and in progress	3 months

Regulation 21: Privacy

Report reference: Page 38

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
10. The registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times, as the observation panel on the seclusion door did not have blinds or/curtains.	*New*	Corrective Action(s): New glass panel with blind insitu to be sourced. Funding to be approved Post-Holder(s) responsible: CNM3	Privacy analysis	Maybe delay getting specialised glass to fit door. However realistic and in progress	5 months
		Preventative Action(s):All staff have signed to say that they have read and understood the policy. Training on regulation 21 privacy to be provided to all staff. New seclusion pack to commence which will outline the need to uphold the privacy and dignity of all residents, an informational session will be provided in regards to same Post-Holder(s) responsible: A/ADON and CNM3 CNM2	Analysis every two months	Realistic and in progress	3 months

Regulation 22: Premises

Report reference: Pages 39 & 40

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
11. The approved centre was not clean and maintained in good structural and decorative condition, 22(1)(a). 12. The approved centre was not adequately lit or ventilated, 22(1)(b). 13. The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22 (2). 14. Ligature points in the approved centre had not been minimised to the lowest practicable level, 22 (3).	*Monitor as per condition*[1]	New Chairs now in unit Business plan for lighting And ventilation now put in New ligature audit to be completed./	Audit and analysis/	Realistic and in Progress	3 months

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

Regulation 26: Staffing

Report reference: Pages 45, 46 & 47

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
15. The numbers and skill mix of staffing were not sufficient to meet the resident needs, 26 (2).	*New*	Corrective Action(s): To have a meeting with Head of Psychology / Clinical Director/ ADON / CNM3 in relation to psychology groups in the approved centre Post-Holder(s) responsible: CNM3	Copy of correspondence Minutes of any meetings	Realistic and being organised	2months
		Preventative Action(s): New psychology informed groups to commence. New 0.5 OT to commence work in approved cenre Post-Holder(s) responsible:. Head of Psychology, CNM3/ Adon APU, Clinical Director	Audit and analysis on therapeutic services and programmes	Achievable and in progress	5 months
16. Not all staff were up-to-date with required mandatory training, 26 (4).	*Reoccurring*	Corrective Action(s): Continue with providing training for all staff Post-Holder(s) responsible: ADON APU	Audit and analysis	Achievable and in progress	12 months
		Preventative Action(s): All staff have signed to say that they have read and understood the policy. Training needs analysis continues to be updated.			

		All MDT Staff to be informed of the requirement to have Fire training Pmav, Mental Health Act and BLS to be up to date and a copy of their training to be available to their heads of discipline Post-Holder(s) responsible:Clinical Director, CNM3/ ADON APU . All Heads of Disciplines.			

Regulation 27: Maintenance of Records

Report reference: Pages 48 & 49

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
17. Records were not maintained in good order, as there were loose pages, nor were they kept in a safe and secure place 27(1).	*Reoccurring*	Corrective Action(s): All records now in good order Post-Holder(s) responsible: A/ADON and CNM3, CNM2s and all clinical staff.	Regular audit and analysis	Realistic and on going due to high level of admissions in APU.	All charts now in good order but ongoing 12 months
		Preventative Action(s): All staff have signed to say that they have read and understood the policy. Training on Regulation 27 maintenance and other National policies in relation to record keeping Post-Holder(s) responsible: A/ADON	Documention of staff who have been trained and to include in new staff orientation	Achievable and in progress	3 months

Regulation 32: Risk management procedures

Report reference: Pages 55 & 56

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
18. The approved centres risk management policies did not address the process of identification, assessment, treatment, reporting, and monitoring of ligature points throughout the approved centre, 32 (1)	*New*	Corrective Action(s): This is now addressed in polocy Post-Holder(s) responsible: Director of Nursing	Audit and analysis . Audit the policy from the Judgement Support Framework	Achieved	Completed
		Preventative Action(s): All staff have signed to say that they have read and understood the policy on risk management Post-Holder(s) responsible: CNM3	Completed signatiure log	Achieved	Completed

Rules: The Use of Seclusion

Report reference: Pages 59 & 60

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
19. Residents in seclusion did not have access to adequate toilet and washing facilities, as the toilet/washing room facilities were along the corridor from seclusion in the high observation unit, 8.1.	*New*	Corrective Action(s): To put forward business plan. Post-Holder(s) responsible: CNM3/ ADON APU	Seclusion audit which incorporates access to toilet/ washing facilities	Approval of Funding to completey renovate high obs area	12 months
		Preventative Action(s): Safewards used in APU Ennis to reduce use of seclusion Post-Holder(s) responsible: CNM3	Annual report on seclusion	Achievable	12 months
20. In one case, the responsible consultant psychiatrist did not enter a date beside their signature, making it difficult to determine if they had signed the seclusion register within 24 hours, 3.5 21. In one case the resident was not medically reviewed every four hours, 5.4.	*New*	Corrective Action(s):To be discussed at consultants meeting all medical personnel to be trained on the rule of seclusion and the new seclusion pack in order to be compliant with seclusion Post-Holder(s) responsible: Clinical Director , CNM3 and CNM2	Seclusion audits 2 monthly	Realistic and in progress	2 months
		Preventative Action(s): New seclusion pack training Post-Holder(s) responsible:CNM2			2 months
22. In no case were residents informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion. The reason for this was not documented in a clinical file, 3.6.	*New*	Corrective Action(s): New seclusion pack which meets the requirement of the Rule of Seclusion Post-Holder(s) responsible:	Seclusion audits to ensure requirements of the rule are met.	Realistic and in progress	2 months

23. In one case, the resident's representative was not informed, and the reason for this was not recorded in a clinical file, 3.7(a). 24. In no case were the residents informed of the ending of an episode of seclusion; nor was this recorded, 7.3 and 7.4.		CNM2			
		Preventative Action(s): Master class on the rule of seclusion and the new pack Post-Holder(s) responsible: CNM2	Seclusion audits to ensure requirements of the code are met	Realistic and in progress	2 months
25. In two cases, the episode of seclusion was not reviewed by members of the multi-disciplinary team and documented in clinical file within two working days, 10.3	*New*	Corrective Action(s):MDT reviewing episodes of seclusion within two working days Post-Holder(s) responsible: Clinical Director	Seclusion audits to ensure requirements of the code are met	Achieved and on going	Completed and ongoing
		Preventative Action(s): Training on rule of seclusion and new seclusion pack Post-Holder(s) responsible: CNM2	2 monthly seclusion audits	Realistic and due to commence	2 months

Code of Practice on the Use of Physical Restraint in Approved Centres

Report reference: Pages 63 & 64

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
26. In one case, the consultant psychiatrist or duty consultant psychiatrist was not notified as soon as was practicable, 5.3. 27. In one case, that form was not signed by a clinical psychiatrist within 24 hours, 5.7(c). 28. In one case, a registered medical professional did not complete a medical examination within three hours of the end of the episode, 5.4.	*Reoccurring*	Corrective Action(s): All episodes of physical reviewed to ensure they meet the code of practice on physical restraint Post-Holder(s) responsible: CNM3	Audit	Achieved	Completed
		Preventative Action(s): New physical restraint checklist insitu that meets requirements of code, training to be provided on same Post-Holder(s) responsible: A/ADON	Audit and analysis	Achievable and in progress	2 months
29. In one case, there was no evidence that the resident was informed of reasons for, likely duration of, or circumstances leading to discontinuation. The reason for this was not documented in the clinical file, 5.8.	*New*	Corrective Action(s): All staff orientated and training commenced on Code of Practice on physical restraint and new checklist Post-Holder(s) responsible: A/ADON	Documentation of staff who have been trained	Achievable and in progress	2 months
		Preventative Action(s): On going training and informational sessions / training also for all new mdt staffon induction			

		Post-Holder(s) responsible: CNM3 and all Heads of Disciplines			
30. In one case, the resident did not have the opportunity to discuss the episode with members of the multi-disciplinary team, 7.2. 31. In one case, the episode was not reviewed by members of the multi-disciplinary team and documented within two working days.	*Reoccurring*	Corrective Action(s): Memo to be sent to MDT staff about the findings oof the draft report and the need for compliance with the code of practice Post-Holder(s) responsible: Clinical Director and CNM3	Copy of memo	Achievable and realistic	2 weeks
		Preventative Action(s): Ongoing training and informational sessions in place Post-Holder(s) responsible: Clinical Director and A/ADON	Documentation of staff who have been trained	Achievable an drealistic	2 months

Code of Practice on Admission of Children

Report reference: Page 65

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
32. Age-appropriate facilities and a programme of activities were not provided by the approved centre, 2.5(b).	*Reoccurring*	Corrective Action(s): For all Mental Health teams to make best efforts in sourcing a CAMHS bed if required Post-Holder(s) responsible Clinical Director	Audit and analysis	Realistic	12 months ongoing
		Preventative Action(s): To continue to liase with CAMHS Services and source beds with them in the event they are required Post-Holder(s) responsible: Clinical Director, ADON APU, CNM3	Audit and analysis	Realistic	12 months ongoing
33. Children did not have access to child advocacy services, 2.5(g).	*New*	Corrective Action(s): Unable to source child advocacy services., will continue to liase with National organisations and other CHO areas to source same Post-Holder(s) responsible: A/ADON	Documentation and correspondence to be maintained in relation to sourcing same	Unable to source at present / to liase with CAMHS services in relation to this.	2 months
		Preventative Action(s): Will source child advocacy services Post-Holder(s) responsible: A/ADON	Audit and analysis following child admissions	No child advocacy services available up to 2018, will further research and review with other CAMHS services and CHO areas	3 months

34. The approved centre did not record the child's understanding of their rights and information about the wards and facilities, 2.5(h).	*New*	Corrective Action(s): New checklist to be completed to ensure no requirements of the code have not been left out Post-Holder(s) responsible: CNM3	Audit and analysis and action plan following any child admissions	achievable	3 months
		Preventative Action(s): Training on the code of admission of children Post-Holder(s) responsible A/ADON	Records to be kept on staff who have been trained	achievable	3 months

Code of Practice on Admission, Transfer and Discharge

Report reference: Pages 66 & 67

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
35. Admission assessments did not include a risk assessment, 15.3	*New*	Corrective Action(s):All RMPs informed of the need for a risk assessment prior to admission. This risk assessment is documented in the clinical file on the admission note Post-Holder(s) responsible:Clinical Director and CNM3	Audit and analysis	Achievable	2 weeks
		Preventative Action(s): New admission checklist available and training to be provided Post-Holder(s) responsible: A/ADON	Audit to ensure checklist is complete and records kept of any training	Achievable and in progress	2 months
36. Discharge plans did not did not include references to early warning signs of relapse and risk, 34.2. 37. Discharge assessments did not include a current mental state examination, a comprehensive risk assessment and risk management plan, or informational needs, 34.4. 38. There was no evidence that preliminary discharge summaries were sent to the appropriate health practitioner within three days, 38.3. 39. There was no evidence that comprehensive discharge summaries were issued within 14 days, 38.3(b). 40. There was no evidence that resident representatives were involved in discharge process, 39.1.	*Reoccurring*	Corrective Action(s):All RMPs informed Post-Holder(s) responsible:Clinical Director	Ongoing audit and analysis	realistic	2 weeks
		Preventative Action(s): New checklist/ pro forma insitu to meet the requirements of the code.Training to be provided Post-Holder(s) responsible: A/ADON	Audit to ensure checklist is complete and records kept of any training	realistic	2 months