Drogheda Department of Psychiatry

ID Number: AC0099

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Drogheda Department of Psychiatry
Crosslanes
Drogheda
Co Louth

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

Most Recent Registration Date:
1 September 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Ger McCormack, General Manager, Mental Health Services, MLM CHO

Inspection Team:
Martin McMenamin, Lead Inspector
Siobhán Dinan
Aisling Nestor
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Inspection Date:
17-20 July 2018

Previous Inspection Date:
5 – 8 September 2017

Inspection Type:
Unannounced Annual Inspection

Date of Publication:
Thursday May 2nd 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2018 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Not applicable</th>
<th>Non-compliant</th>
<th>Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>5</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>2017</td>
<td>4</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>2018</td>
<td>4</td>
<td>12</td>
<td>23</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2017</td>
<td>2</td>
<td>11</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2018</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>
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1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

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

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

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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, 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.
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

Drogheda Department of Psychiatry was a 46-bed purpose-built acute mental health unit. The approved centre was located close to, but separate from, the campus of Our Lady of Lourdes Hospital. There was no governance relationship with Our Lady of Lourdes Hospital; however, the Louth Meath Mental Health Service did have a liaison team based in the general hospital. The approved centre provided acute in-patient services to counties Louth and Meath.

Seven sector teams from Louth, including two Mental Health Service for Older Persons (MHSOP) teams, were responsible for Louth residents in the approved centre and provided in-reach care with weekly multi-disciplinary meetings. In contrast, Meath residents were under the care of a single in-patient locum consultant while in the approved centre and were transferred back to the care of their community team on discharge.

Compliance with regulations, rules and codes of practice has decreased between 2016 (77%) and 2018 (66%). However, there were nine compliances rated as excellent and there was an impressive list of recently developed quality initiatives (outlined below). There were no conditions to the registration of the approved centre.

Safety in the approved centre

Food safety was audited regularly and kitchen areas were clean. While ordering and storing of medication was satisfactory, there were a number of deficits in the prescribing and administration of medication which carried a risk of medication errors. Not all staff had up to date training in fire safety, Basic Life Support, the management of violence and aggression, and the Mental Health Act 2001. Each resident had an individual risk assessment and risk management plan where indicated.

Appropriate care and treatment of residents
Each resident had a multi-disciplinary care plan which was developed with the resident and reviewed regularly. The provision of therapeutic services and programmes was excellent. Therapies were evidence-based and in accordance with residents’ individual needs. There were adequate facilities for the provision of therapeutic intervention.

Access to medical care was available. While six-monthly physical assessments were carried out, they were not completed in line with best practice and the relevant regulation.

**Respect for residents’ privacy, dignity and autonomy**

All bedrooms were single, en suite rooms. Residents wore their own clothes and maintained control over their own property but there was an insufficient supply of emergency clothing available. There was space for residents to meet visitors in private and the residents were free to communicate as they wished. CCTV was used in a way that was respectful of residents’ privacy and dignity.

The request for consent and the received consent were not documented for every search of a resident and every property search. A clinical file with identifiers and other clinical documentation could be seen from the corridor on a desk in the nurse’s office during the inspection. The gardens in the psychiatry of old age and acute units in the approved centre were overlooked by houses across the street. Other parts of the approved centre were conducive to residents’ privacy and dignity.

Seclusion was used in the approved centre and was in compliance with the Rule Governing the Use of Seclusion. There were five non-compliances with the Code of Practice on Physical Restraint.

**Responsiveness to residents’ needs**

There was a choice of food at mealtimes which was nicely presented. There was insufficient access to recreational activities especially in the high dependency unit. There was access to spiritual care if requested.

The approved centre was clean and well maintained internally and externally with access to gardens.

**Governance of the approved centre**

Drogheda Department of Psychiatry was part of the HSE Community Health Organisation (CHO) Area 8, providing in-patient services following referrals from counties Meath and Louth. There was an organisational chart and clear governance structures and processes in place reflecting the Louth/Meath Mental Health Service, which was led by the Area Management Team consisting of the Executive Clinical Director (Chairperson). This group reports to the Lead in Mental Health for Midlands Louth/Meath CHO.

Governance presents a challenge given the nature of the historical service delivery models of Louth and Meath, where concerns remain about the potential risks posed by having two operating models depending on the home address of a resident. The Area Management Team were aware of this and were developing integrated systems of operations, which maintain the best of both models.

Health and safety risks were documented within the corporate risk register, as appropriate. There was evidence that the risk register was a live document within the unit, actively managed and reviewed with
trend analysis of risk category, status, rating, and actions displayed on a dashboard. The key challenges for the service included bed management and recruitment of staff, which were reflected in the risk register.

There were 14 nursing vacancies, most of which were at the clinical nurse manager grades.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Development of a demonstration site as part of the clinical care programmes for early intervention psychosis.

2. Further planning and development for self-referrals and out of hours’ service at Our Lady of Lourdes Hospital.

3. Introduction of a full-time non-consultant hospital doctor to improve medical services within the approved centre.

4. Introduction of a communication booklet developed for Psychiatry of Old Age, aimed at providing a better understanding and profile of residents in terms of their interests, likes, needs, wishes and preferences.

5. Introduction of handover communication tool ISBAR (Identify-Situation-Background-Assessment-Recommendation) within all wards.

6. Following the introduction of the HSE Best Practice Guidelines (2016), training of quality champions has been facilitated and a self-assessment team has been identified to undertake audit and evaluation of practice.

7. The approved centre has introduced the Broset Violence Checklist, a dynamic assessment of risk of aggression and violence towards others including staff.

8. A discharge booklet created by Advancing Recovery in Ireland to complement the approved centre’s resident information booklet has been developed.

9. Improvements have been undertaken to enable disability access to external garden.

10. Enhancement of perimeter fencing to increase the security of the approved centre.

11. Relocation of pharmacy storeroom and the development of a dedicated physical and medical examination room.

12. The introduction of a new cloud based Safety Management System which contains all relevant documents related to health and safety.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

Drogheda Department of Psychiatry was a purpose-built acute mental health unit which replaced separate acute facilities in Navan and Ardee, and had been open to admissions since 5th September 2016. The approved centre was located close to, but separate from, the campus of Our Lady of Lourdes Hospital. There was no governance relationship with Our Lady of Lourdes Hospital; however, the Louth Meath Mental Health Service did have a liaison team based in the general hospital.

The approved centre provided acute in-patient services to counties Louth and Meath. It consisted of 46 beds; 38 acute admission beds (including a 4-bed high observation unit) and 8 beds for psychiatry of later life. All bedrooms were single, en suite rooms. All resident accommodation was located on the ground floor, while office and staff facilities were located on the first floor.

Seven sector teams from Louth, including two Mental Health Service for Older Persons (MHSOP) teams, were responsible for Louth residents in the approved centre and provided in-reach care with weekly multidisciplinary meetings. Meath residents were under the care of a single in-patient locum consultant while in the approved centre and were transferred back to the care of their community team on discharge.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>46</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>44</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>6</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>2</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>14</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance
Drogheda Department of Psychiatry was part of the HSE Community Health Organisation (CHO) Area 8, providing in-patient services following referrals from counties Meath and Louth. There was an organisational chart and clear governance structures and processes in place reflecting the Louth/Meath Mental Health Service, which was led by the Area Management Team consisting of the Executive Clinical Director (Chairperson). This group reports to the Lead in Mental Health for Midlands Louth/Meath CHO.

Governance can present a challenge given the nature of the historical service delivery models of Louth and Meath, where concerns remain about the potential risks posed by having two operating models depending on the home address of a resident. The Area Management Team were aware of this and were developing integrated systems of operations which maintain the best of both models. To achieve this, a number of key groups and committees reported to the Area Management Team on a monthly basis. This ensured that there was appropriate communication and delivery of agreed actions, and included: Clinical Governance Group, Acute Forum group, Interim Care Group, Individual Discipline Groups, and Special Project Groups. Copies of the minutes of the Area Catchment Management Team Clinical Governance meeting, Multi-Disciplinary Team (MDT) Executive Management Team Meeting, CHO, and Leadership groups were provided to the inspection team.

Seven sector teams from Louth, including two Mental Health Services for Older Persons (MHSOP) teams, were responsible for Louth residents in the approved centre and provided in-reach care with weekly multidisciplinary meetings. Meath residents were under the care of a single in-patient locum consultant, and supported by a non-consultant hospital doctor, while in the approved centre. Residents were transferred back to the care of their community team on discharge. Heads of disciplines and teams were responsible for the implementation and delivery of the clinical governance agenda within their own area.

Health and safety risks were documented within the corporate risk register, as appropriate. There was evidence that the risk register was a live document within the Unit, actively managed and reviewed with trend analysis of risk category, status, rating, and actions displayed on a dashboard. The key challenges for the service included bed management and recruitment of staff, which were reflected in the risk register. The unit had consistently high bed occupancy rates partly due to a lack of suitable community accommodation for residents who were fit for discharge, and self-referrals currently presenting to the Drogheda Department of Psychiatry (DDOP). Bed management was further compounded by the lack of a clear contingency plan when the unit or service has no free beds.

On inspection the DDOP had a number of staff vacancies. Of note were 14 nursing vacancies, most of which were at the clinical nurse manager grades, and this deficit was reflected by the skill mix of staff during the inspection. This was likely impacting on the consistency of day to day service delivery. However, the minutes of the Multidisciplinary Executive Management Team clearly indicate active management of both the identified staffing issues and also the need for improved triage, referral, and discharge pathways of care.

4.5 Use of restrictive practices

There were no instances of restrictive practices observed.

5.0 Compliance
5.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td>✓</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X High</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X Low</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice: Use of Physical Restraint in Approved Centres</td>
<td>X Moderate</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice relating to the Admission of Children under the Mental Health Act 2001</td>
<td>Not applicable</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.
5.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 8: Residents Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
</tr>
</tbody>
</table>

5.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Area Lead from the HSE Mental Health Engagement Office was contacted.

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 eight residents individually. Residents were satisfied with the food quality and choice, respect for their privacy, and process for visitation. The majority of residents were satisfied with the amount of activities available to them. Residents reported having good access to the multi-disciplinary team and positive interaction with staff. Three residents raised a concern of feeling unsafe in their environment. All the residents interviewed had a very clear understanding of their care plan and treatment, and knew their key worker, although there was also a lot of rotation of key workers identified by residents.

It was also identified from some resident feedback that they felt that their admission was longer than was necessary, due to a lack of suitable accommodation post-discharge. Despite efforts by the Clinical Director and team to engage with the local Council to progress each individual resident’s needs, the residents involved stated that they were very frustrated with this situation.

The inspection team noted the report compiled by the Irish Advocacy Network (IAN) in July 2017 and forwarded to the Mental Health Commission, detailing service user concerns. The report referred to concerns about locked doors on the units, residents not having the opportunity to speak in their care plan meetings, restrictive access to the phone charger station, restricted access to the garden spaces (internal garden was frequently closed) and not having enough activities on the unit. The report also identified that staff were sometimes not responsive to resident needs, as they were too busy, and residents were occasionally left to wait standing outside the nurse’s station. Dignity and privacy was also felt to be compromised by residents with regard to the mode of medication administration, that is, whilst queueing outside the clinical room to receive their medication. Problems with plumbing were also mentioned, such as difficulty flushing toilets and poor water flow in sinks.
Where any resident brought a matter to the attention of the inspectors during the inspection process, that query or concern was relayed to clinical and administrative staff, who undertook to follow it up, where appropriate.
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:

- Area Director of Nursing/Quality & Risk Manager
- Principal Psychologist
- Principal Social Worker
- Senior Occupational Therapy
- Acting Occupational Therapy Manager
- Acting Mental Health Administrator
- Registered Proprietor/General Manager
- Clinical Nurse Manager 3
- Assistant Director Nursing
- Catering Manager

Apologies were received from the Executive Clinical Director.

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.
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

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 May 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 identifying residents, as set out in the policy.

Monitoring: An annual audit was 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: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs. The approved centre used a photo, date of birth, and wristbands, but alternatives were used if a resident preferred. The preferred identifiers used for each resident were detailed within residents’ clinical files.

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. A red sticker system was used to alert staff to residents with the same or similar names.

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 5: Food and Nutrition

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

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

### INSPECTION FINDINGS

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

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 not been completed to identify opportunities for improving the processes for food and nutrition.

**Evidence of Implementation:** Dietician input was sought through a referral process when a need had been identified by a resident, or where the treating team identified a dietary issue. Residents were provided with a variety of wholesome and nutritious food, which was presented in an attractive and appealing manner. Residents had three options for main meals, and residents were given the menu choice the day before. Hot meals were provided daily. There was access to safe, fresh water on every unit and residents could access it themselves. Hot and cold drinks were provided in-between main meals.

For residents with special dietary needs, their nutritional and dietary needs were assessed and, where necessary, addressed in residents’ individual care plans. These needs were regularly reviewed by a dietician. Residents and their representatives were educated about residents’ diets and actively involved in the resident’s care. An evidence-based nutrition assessment tool (the Malnutrition Universal Screening tool (MUST) tool) was used, and weight, intake, and output charts were maintained where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
### Regulation 6: Food Safety

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

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

### INSPECTION FINDINGS

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

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

**Monitoring:** Food safety audits had been completed periodically. Food temperatures were 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 a very high standard to support food safety requirements. All surfaces and equipment were clean.

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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in May 2017. The policy did not address processes for the use of night and day clothing and recording the wearing of nightclothes during the day in the resident’s individual care plan.

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. The clothes were clean and appropriate to resident needs, and there was an adequate supply of individualised clothing. Next of kin were contacted if residents needed more clothes, and. Residents changed out of nightclothes during daytime hours unless specified otherwise in their ICPs.

Residents’ only supply of emergency clothing was night clothes, there was no underwear available. Whilst a clothing fund was available if needed, it may not always be possible to facilitate access to funds on a weekend or bank holiday.

The approved centre was non-compliant with this regulation because residents did not have access to emergency personal clothing that was appropriate and took account of their dignity and bodily integrity, 7(1).
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in April 2016. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Personal property logs were monitored by nursing staff 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. On admission, a resident property checklist was compiled, which was updated as necessary. The checklist was kept separately to the resident’s individual care plan (ICP) and was available to residents. Personal property and possessions were safeguarded when the approved centre assumed responsibility.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. A safe was available in each unit for resident’s monies and valuables. Personal property and possessions could be stored in resident’s single rooms or in property boxes in store rooms.

Access to, and use of, resident monies was overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, receipts of purchases were retained, and a cash log was signed by the two staff members who issued the money, and counter-signed by the resident or their representative, where possible.

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 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in August 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre did not provide access to recreational activities appropriate to the resident group profile. Residents in the high observation ward had minimal access to recreational activities, and access for general adult residents was mostly self-directed. Recreational activities were led by nurses, based on staffing levels. Nurse-led recreational activities happened mostly at the weekends.

The recreational activities provided by the approved centre were appropriately resourced. There were suitable communal areas for recreational activities to take place except high observation, where residents only had a TV room. Whilst each unit has an outdoor gym, high observation and general adult residents did not have any access to indoor physical activity.

Recreational activities programmes were developed, implemented, and maintained with resident involvement, within community meetings held monthly. Information was not provided to residents in an accessible format, and did not include the types and frequency of recreational activities. Individual risk assessments were completed for residents, where appropriate, in relation to the selection of appropriate activities. Residents can play table tennis and pool when supervised and risk assessed. Resident decisions on whether or not to participate in activities were respected and documented. Documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file.

The approved centre was non-compliant with this regulation because the approved centre did not provide access to recreational activities appropriate to the resident group profile.
Regulation 10: Religion

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

INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in July 2016.

**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 their religion were facilitated within the approved centre. Residents also had access to local religious services and were supported to attend Mass outside the unit. There were facilities within the approved centre for residents’ religious practices, with a large non-denominational room available for all religious preferences. Residents 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

(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 written policies and procedures in relation to visits, which were last reviewed in September 2016. The policies and procedures addressed requirements of the Judgement Support Framework, with the exception of outlining the required visitor identification methods.

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

Monitoring: 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. A separate room was provided where residents could meet visitors in private, unless there was an identified risk. The visiting rooms were suitable for visiting children.

Appropriate steps were taken to ensure the safety of residents and visitors during visits, including the use of private visiting rooms, risk assessments, and resident observation as per their risk assessments. Visiting children were accompanied at all times to ensure their safety, and this was publicly communicated.

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

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(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 written operational policies and procedures in relation to resident communication, which were last reviewed in October 2016. The policies 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 policies. Relevant staff interviewed were able to articulate the processes for communication, as set out in the policies.

Monitoring: At the time of inspection no resident had restrictions in place on communication. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, phone, email, and internet. Residents had access to a cordless phone and payphone, and some residents had their own mobile phone. Residents could access a computer with the internet for a fee of €1 per 12 minutes. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and documented in their individual care plan. The clinical director would supervise the opening of mail if there was an assessed risk, however no resident had any risks associated with their external communication.

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 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the implementation of resident searches, which were last reviewed in September 2016. The policies 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 policies and procedures did not address 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 policies. Relevant staff interviewed were able to articulate the searching processes, as set out in the policies.

Monitoring: A search log was available but recorded only searches that staff considered to be an official search. Each recorded search record had not been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had not been completed to identify ways of improving search processes.

Evidence of Implementation: Not all searches were recorded. Bags were searched when a resident returned from leave. However, staff did not document this as a search unless contraband was found. Where recorded, searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Risk was assessed prior to a search of a resident, their
property, or the environment. A minimum of two clinical staff were in attendance at all times when searches were conducted. Recorded searches were implemented with due regard to the resident’s dignity, privacy, and gender. At least one staff member conducting the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why. Verbal consent was not sought from each resident prior to all searches. There was no documented evidence that general written consent was sought for routine environmental searches. Staff considered that personal searches were the same as environmental searches.

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

(a) The request for consent and the received consent were not documented for every search of a resident and every property search (4).
(b) General written consent was not sought for routine environmental searches, 13(5).
(c) A written record of every search of a resident and every property search was not available, 13(9).
(d) A written record was not kept of all environmental searches, 13(9).
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and protocols in relation to care of the dying, which were last reviewed in May 2017. The policies and protocols 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 policies. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policies.

The monitoring and evidence of implementation pillars could not be assessed against as no death had occurred since the last inspection.

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

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

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

INSPECTION FINDINGS

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

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not 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: Ten ICPs were reviewed on inspection. The ICPs were a composite set of documents, which were identifiable and uninterrupted, stored within clinical files, and not amalgamated with progress notes. All residents were assessed pre-admission and at admission, and had initial care plans completed by the admitting clinician to address their immediate needs. Comprehensive assessments and ICP’s were completed within seven days of admission. ICPs were discussed, drawn up, and agreed with the participation of residents, and where appropriate their representatives. ICPs were reviewed and updated weekly by the MDT.

The ICPs were comprehensive and included resident goals, needs, treatment, resources required, medical history, and current physical health assessment, amongst several other sections. All ICPs identified a keyworker and primary nurse to ensure continuity of implementation, and included risk management plans and a preliminary discharge plan where appropriate. Evidence-based assessments were used where possible.

Residents had access to their ICPs and were kept informed of any changes. Residents were offered copies of their ICP, including any reviews. This was documented. When a resident declined or refused a copy of their ICP, this was recorded.

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 16: Therapeutic Services and Programmes

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in December 2016. 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 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:** The therapeutic services and programmes were appropriate, met the assessed needs of residents as documented in their individual care plans, and were evidence-based. A standardised assessment form was used to identify resident needs. Residents were assessed by an occupational therapist prior to assessing group and individual programmes. These assessments were well documented in each resident’s integrated care plan, and were retained in their clinical file. The services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of services and programmes was provided in the main communal area. An occupational therapist provided group and individual programmes and schedules to psychiatry for old age, general adult, and high observation residents. Where a resident required a service or programme that was not provided internally, external practitioners were employed on a sessional basis to provide the service. Practitioners included physiotherapists and physical health occupational therapists, amongst others.

Services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies, including a kitchen, art studio, and therapeutic room. The rooms were appropriately resourced. A record was maintained of participation and engagement in services or programmes in resident’s individual care plans or clinical files.

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 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in May 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 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: Residents were assessed prior to transfer, including an individual risk assessment; this was documented and provided to the receiving facility. Verbal communication and liaison occurred between the approved centre and the receiving facility prior to transfers. Full and complete written information was sent in advance and accompanied the resident upon transfer, to a named individual. Information included a letter of referral, medication requirements, and a transfer form. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred. In emergency transfers, communications between the approved centre and the receiving facility were documented and followed up with written referral.

Copies of all records relevant to the resident transfer were retained in the resident’s clinical file. Records of the resident’s consent to a transfer were available, or the justification as to why consent was not received. Communication records with receiving facility were documented.

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 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which were last reviewed in July 2018 and September 2015 respectively. 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 not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: Five files were reviewed on inspection. Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis. Residents received appropriate general health care interventions in line with individual care plans.

Residents’ general health needs were monitored and assessed, every six months. The assessment included a physical examination, family and personal history, smoking status, nutritional status, medication review, and checking BMI, weight, blood pressure, and dental health. However, the assessment did not include waist circumference measurement. For residents on antipsychotic medication, there was an annual assessment of glucose regulation (fasting glucose/HbA1c), blood lipids and electrocardiogram. However, in two of the three relevant files prolactin levels were not checked.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services including a chiropodist, optician, speech and language therapist, and dentist as required. Residents had access to appropriate national screening programmes. However, no information was available regarding the national screening programmes to residents. Residents had access to smoking cessation programmes and supports.

Records were available demonstrating the residents’ completed general health checks, the associated results, and any medical emergencies and the care provided. The approved centre had an emergency bag and an Automated External Defibrillator (AED), which were checked weekly.
The approved centre was non-compliant with this regulation for the following reasons:

a) All six-monthly general health assessments inspected did not document waist circumference, 19 (1b).

b) For two residents on antipsychotic medication, there was no evidence to suggest prolactin levels were monitored annually, 19 (1b).
Regulation 20: Provision of Information to Residents

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

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the provision of information to residents, which were last reviewed in May 2017. The policies and procedures included all of the requirements of the Judgement Support Framework.

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

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: Required information was provided to residents and/or their representatives at admission, including the approved centre’s information booklet. The booklet was available in the required format, was clearly and simply written, supported residents’ needs, and contained details of:

- Care and services.
- Housekeeping arrangements, including arrangements for personal property and mealtimes.
- Complaints procedures.
- Visiting times and arrangements.
- Resident’s rights and relevant advocacy and voluntary agencies.
- Details of the multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis, unless such information might be prejudicial to the residents’ health or well-being. The justification for restricting information regarding a resident’s diagnosis was documented. Information was provided on request to residents on the likely adverse effects of treatments, including the risks and other potential side-effects. Medication information was provided in a format appropriate to resident needs. Medication information sheets included
information on indications for use of all medications to be administered to the resident, including any possible side-effects. The information in the documents provided to residents was evidence-based, and appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as required.

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 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in May 2017. The policy addressed requirements of the Judgement Support Framework, except for identifying a method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.

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 a professional demeanour and dress, communicated with residents appropriately, used residents’ preferred names, and sought resident permission before entering their room. All residents wore clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls, with a cordless phone and pay phone provided.

A clinical file with identifiers and other clinical documentation could be seen from the corridor on a desk in the nurse’s office. The gardens in the Psychiatry of Old Age and Acute Units in the approved centre were overlooked by houses across the street.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. Locks had an override function. Observation panels on doors of treatment rooms were generally closed. Panels were only opened for night time observation and when residents requested that it was opened for their room. Each nurse had a master key to open the observation panel. Noticeboards did not display resident names or other identifiable information.

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

a) The registered proprietor did not ensure that the resident’s privacy and dignity was appropriately respected at all times as a clinical file and clinical documentation was on view to anyone passing the nurses office.

b) The registered proprietor did not ensure that the resident’s privacy and dignity was appropriately respected at all times as privately owned houses were overlooking the gardens.
(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in June 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 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. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and appropriately sized bedrooms and communal rooms. A new sitting room had been built and there were six outdoor areas. There was a sufficient number of accessible and well sign-posted toilets and showers for residents in the approved centre. The approved centre had a sluice room, cleaning, laundry room, and dedicated therapy and examination rooms. The approved centre was well heated, well lit, ventilated, and did not have excessive noise. However, heating could not be controlled in the resident’s own room. Remote or isolated areas of the approved centre were monitored.

The approved centre had appropriate signage and sensory aids to support resident orientation needs. Hazards and ligature points were minimised. Furnishings, assisted devices, and equipment supported resident independence, needs, and comfort. The approved centre was clean, hygienic and free from offensive odours. Current national infection control guidelines were followed.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive
equipment. Maintenance was reactive, with problems reported as they arose. Where substantial changes were required, this was appropriately assessed prior to implementation for possible impact on residents and staff. The Mental Health Commission was informed prior to the commencement of works. Back-up power was available to the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in May 2018. The policy addressed requirements of the Judgement Support Framework, except that it did not identify:

- The roles and responsibilities for the ordering, prescribing, storing, and administration of medication.
- The process applied when medication is refused by the resident.
- The processes for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.
- The process for reviewing resident medication.

Additionally, the policy did not reflect legislative changes to the Mental Health Act 2001 in 2015, which removed reference to ‘unwilling’ in relation to consent.

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. Relevant training was documented.

Monitoring: There was no evidence of quarterly audits of Medication Prescription and Administration Records (MPARs) 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 not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARs were reviewed on inspection. All MPARs were legible and written in black, indelible ink, and had dedicated space for routine medications, once-off medications, and “as required” medications. Not all MPARs recorded two appropriate resident identifiers. The generic names of the medication and preparation were identified and written in full. MPARs recorded the date of initiation and discontinuation for each medication, as well as the dose/amount to be given. Every MPAR included the appropriate registration number of the health practitioner prescribing medication. Each entry was signed by a health practitioner. However, on each of the following; one or more of the ten MPARs did not:

- Record frequency of administration, including the minimum dose interval for PRN medication.
- Record the administration route for medication.
- ‘Micrograms’ were not written in full text format.
• State specifically which medications a resident was allergic to, only that the resident had allergies.
• Identify medications refused by the resident.
• Include a justification for why a resident’s medication was withheld.
• Record medications refused by the resident, the clinical file also did not note this.
• Record all medications administered to the resident.

All medicines were administered by a registered health professional in line with the directions of the prescriber and pharmacist. The expiration date of the medication was checked prior to administration; expired medications were not administered. Schedule 2 controlled drugs were checked by two staff members, including a registered nurse, and a controlled drug book was completed. Good hand-hygiene techniques were implemented when dispensing medications. Direction to crush medication was only accepted from the resident’s medical practitioner, with a pharmacist consulted about the type of preparation to be used. Medical practitioners documented what medication was to be crushed, but did not document why the medication was to be crushed.

Residents could self-administer medications where appropriate. Changes to the initial risk assessment were recorded and arrangements for self-administering medicines were kept under review. Nurses, rather than a pharmacist, labelled medications for self-administration.

Medication was stored in a clean, secure, and appropriate environment. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were incorporated in the cleaning and housekeeping schedules.

Medication was reviewed and rewritten at least six-monthly or more frequently, as appropriate, as part of general health checks. However, this was not documented in the clinical notes. In general, prescriptions were rewritten where changes were required. However, in one instance an incorrect dose was written, scored out, and the correct dose was written on top of what was scored through. A system of stock rotation was implemented to avoid accumulation of old stock. However, an inventory of medications was not conducted on a monthly basis. Medications that were no longer required or had expired were stored in a secure manner, segregated from other medication, and returned to the pharmacy for disposal.

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

a) Medication causing allergies were not named, 23(1).
b) Route of medication was not documented 23(1)
c) Not all medications administered to the resident recorded, 23(1).
d) Withholding of medication was not documented in the clinical file, 23(1).
e) The policy did not reflect legislative changes to the Mental Health Act 2001 in 2015, which removed reference to ‘unwilling’ in relation to consent, 23(1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors, which was last reviewed in March 2018. The policy and the safety statement included all of the requirements of the Judgement Support Framework.

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

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

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

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

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:
   (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
   (b) it shall be clearly labelled and be evident;
   (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
   (d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
   (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which were last reviewed in May 2017. The policy addressed all of the requirements of the Judgement Support Framework, including the purpose and function of using CCTV for observing residents in 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: Residents were monitored solely for the purposes of ensuring the health, safety, and welfare of residents. CCTV was not used to monitor a resident if they acted in a way that compromised their dignity. Clear signs were in prominent positions where CCTV cameras or other monitoring systems were located. CCTV cameras, or other monitoring systems used to observe residents, were viewed solely by the health professional responsible for the residents. Neither CCTV cameras nor monitors could record or store a resident’s image in any form. The usage of CCTV or other monitoring systems had been disclosed to the Mental Health Commission and/or the Inspector of Mental Health Services.

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 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to its staffing requirements, which were last reviewed in June 2016. The policies and procedures addressed all of the 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.

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

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 sufficient to meet resident needs. There was an organisational chart to identify the leadership, management structure, and accountability. An appropriately qualified staff member was on duty and in charge at all times. This was documented. A planned and actual staff rota was maintained in the approved centre. The required number of staff were on duty at night to ensure resident safety in the event of a fire or other emergency. Resident feedback and staff interviewed recognised that there was inconsistency in the allocation of key workers for residents due in part to the irregularity of rosters and multi-disciplinary team allocations.

There was a written staffing plan for the approved centre. The plan addressed the skill mix, competencies, number, and qualifications of staff, and the assessed needs of the resident group profile. Staff had appropriate qualifications, and were recruited and vetted in accordance with the approved centre’s policy. Where agency staff were used, there was a comprehensive contract between the approved centre and registered/licensed staffing agency which set out the agency’s responsibilities in relation to potential staff.
Annual staff training plans were completed to identify required training and skills development in line with the assessed needs of the resident group profile. Staff were trained in line with the staff training plan. New staff received an induction and orientation. Training included manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and protection of children and vulnerable adults. However, not all staff were trained in fire safety, Basic Life Support, management of violence and aggression, or the Mental Health Act 2001. All staff training was documented and a logged.

Opportunities were made available and communicated to staff for further education. Appropriate supports, equipment, and facilities were made available and offered to staff. In-service training was completed by appropriately trained and competent individuals.

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.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry of Old Age</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>General Adult</td>
<td>CNM2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>
A number of staff disciplines from community multidisciplinary teams attended the unit when residents on their caseload were admitted.

The approved centre was non-compliant with this regulation because:

a) The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, 26 (4).

b) Not all health care professionals were up to date with required training in the areas of fire safety, Basic Life Support, the management of violence and aggression, 26 (4) and the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the maintenance of records, which were last reviewed in June 2018. 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.
- Record retention periods.
- The destruction of records.

The policies and procedures did not address the following:

- Those authorised to access and make entries in residents’ records.
- Privacy and confidentiality of resident record and content.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed 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. The records of transferred and discharged residents were not included in the review process. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All resident records were constructed, maintained, and used in accordance with national guidelines and legislative requirements. All resident records were physically stored together, where possible. Records were appropriately secured from loss or destruction, tampering and unauthorised access or use.
A record was initiated for every resident assessed or who received care or services by the approved centre. Resident records were maintained using an identifier that was unique to the resident. In two instances, resident records were not reflective of the residents’ current status (voluntary or involuntary). Resident records were not developed and maintained in a logical sequence. Some records did not have volume numbers and one set of clinical records had a duplicate volume number. Records were not maintained in good order, as there were loose pages in some files. Documentation of food safety, health and safety, and fire inspections was maintained.

Resident records were generally maintained appropriately. Entries were factual, consistent, and accurate, and included the date. However, not all entries used the 24-hour clock. Each entry was signed and a record of all signatures used in the resident record was retained. Entries by student nurses or clinical training staff were countersigned by a registered nurse or clinical supervisor. Where information or advice was given over the phone, this was documented appropriately. However, no identifiers were used on one page of a clinical file. One MPAR was written in blue ink instead of black ink. Where an error was made, it was not correctly recorded by scoring the error out with a single line and notating with date, time, and initials.

Resident records were only accessible and editable by authorised staff and residents could access to their records in line with data protection legislation. Staff had access to the data and information needed to carry out their job responsibilities. Records were retained or destroyed in accordance with legislative requirements and the policy of the approved centre.

The approved centre was non-compliant with this regulation because not all records were maintained in a manner to ensure completeness, accuracy, and ease of retrieval, 27(1), due to the following:

- a) Records and reports were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.
- b) Resident records were not reflective of the residents’ current status (voluntary or involuntary).
- c) A number of resident records did not detail volume numbers adequately.
- d) Records were not maintained in good order due to loose pages.
- e) Not all entries noted the time using the 24-hour clock.
- f) Where an error was made on an MPAR the protocol for correcting the error was not adequately followed.
- g) There was no resident identifier detailed on one clinical file.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record:

- Diagnosis on admission, or provisional diagnosis where diagnosis was not available.
- Diagnosis on discharge.

The approved centre was non-compliant with this regulation because the Register was incomplete and did not include all elements as per schedule 1, (2).
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in May 2017. The policies and procedures addressed 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The 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 formatted, approved, and communicated to all relevant staff. 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 had a written statement to this effect (adopting the generic policy).

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 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals, which was last reviewed in September 2016. The policies and procedures addressed all the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre provided excellent private facilities and 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 rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the management of complaints, which were last reviewed in January 2016. The policies and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. 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 not been completed. Complaints data was analysed by a nominated complaints officer. Details of the analysis were provided in monthly reports and 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 in the resident information booklet, with information being well publicised and accessible. Residents and their representatives were assisted to make complaints using appropriate methods and provided contact details for an advocate. There was a nominated complaints officer whom was responsible for dealing with complaints and was clearly identified. There was also a method for addressing minor complaints, which were documented in a log. 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, and outcomes. This was kept distinct from the resident’s individual care plan. However, the complainant’s satisfaction, or dissatisfaction, with the investigation was not documented. Where services, care, or treatment were provided by an external party, the complaints officer was responsible for the full implementation of the approved centre’s complaints management process.

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 monitoring and evidence of implementation pillars.
Regulation 32: Risk Management Procedures

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      i. resident absent without leave,
      ii. suicide and self harm,
      iii. assault,
      iv. accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

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

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

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

Monitoring: The risk register was 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. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, and monitored. Those risks were documented and risk rated in a standardised format. Structural risks, including ligature point, were removed or effectively mitigated. The approved centre implemented a plan to reduce risks to residents while works to the premises were ongoing.

Individual risk assessments were completed upon admission of a resident to the facility, transfer of the resident to another facility, commencement of resident seclusion and commencement of physical restraint. Risk assessments were done in conjunction with medication requirements or administration. However, risk assessment, were not carried out at resident discharge. Multi-disciplinary teams, residents, and their representatives were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented.

All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for trends or patterns. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymised at a resident level.

There was a new and comprehensive emergency plan that specified responses by staff to possible emergencies. The emergency plan incorporated evacuation procedures, and stated that residents could be relocated to St Brigid’s Day Services Department if required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

The approved centre’s insurance certificate was provided to the inspection team. It confirmed that the approved centre was 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

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 no conditions to registration attached. The certificate was displayed prominently in the foyer.

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

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 a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in May 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 was completed.

Evidence of Implementation: Three episodes of seclusion were inspected. Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. Residents in seclusion had access to adequate toilet and washing facilities. Furniture and fittings did not endanger patient safety. Seclusion rooms were not used as bedrooms.

Seclusion was initiated by an appropriate health professional, and a consultant psychiatrist was notified as soon as practicable. Seclusion was only initiated after assessment, including a risk assessment. The registered medical practitioner indicated the duration of the seclusion, which was never more than eight hours. The seclusion initiation and order was recorded. The seclusion register was signed by the responsible consultant psychiatrist within 24 hours, and a medical review was undertaken no longer than four hours after the commencement of seclusion.

The approved centre was compliant with this rule.
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

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 residents 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 one instance, a pro forma Section 60: Consent to the continued administration of medication to whom the Mental Health Act Section 60 applies form was used for a resident who consented and had capacity. In the other case, a written record of consent was completed, which outlined:

- The name of the medication(s) prescribed.
- Confirmation of the assessment of the resident’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of discussion with the resident, including the nature, purpose, effects of the medication(s)
- Any supports provided to the resident in relation to the discussion and their decision-making.
A Form 17 was also completed for this resident, which contained the same information as above, as well as any views expressed by the resident, and 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.
Use of Physical Restraint

NON-COMPLIANT
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 May 2017. 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 no case was there documentary 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 a 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. The consultant psychiatrist or duty consultant psychiatrist was notified as soon as was practicable. This was documented. Cultural awareness and gender sensitivity was demonstrated. A same sex staff member was present at all times during physical restraint where practicable.

In two cases, the registered medical professional did not complete a medical examination within three hours of the end of the episode. In one of the three cases, the resident’s next of kin or representative was not informed of the use of physical restraint, and the reason for this was not recorded in the clinical file. There was no documentary evidence that residents were afforded an opportunity to discuss the episode with members of their multi-disciplinary team.

Each episode of physical restraint was documented in a clinical file. A clinical practice form was completed by the initiator of physical restraint within three hours. That form was signed by a clinical psychiatrist within 24 hours and placed into the resident’s clinical file. There was no evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days.

The approved centre was non-compliant with this code of practice for the following reasons:
a) In two cases, the registered medical professional did not complete a medical examination within three hours of the end of the episode, 5.4.
b) In no case was there documentary evidence in the clinical file that the resident was informed of reasons for, likely duration of, or circumstances leading to discontinuation, 5.8.
c) In one of the three cases, the resident’s representative was not informed of the use of physical restraint, as this was not recorded in the clinical file 5.9(a).
d) There was no documentary evidence that residents were afforded an opportunity to discuss the episode with members of their multi-disciplinary team, 7.2.
e) There was no evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days, 9.3.
## INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the admission of a child, which was last reviewed in August 2018. It addressed the following:

- 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.

The policy did not address the requirement for individual risk assessment of each child.

**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 appropriate to age and ability were not provided. Appropriate accommodation was designated, with all bedrooms being single with an en suite bathroom. Staff observation acknowledged gender sensitivity. Observation arrangements were provided as considered clinically appropriate. Appropriate visiting arrangements for families were available, including children.

Provisions were in place to ensure the safety of the child, respond to the child’s special needs as a young person in an adult setting, and 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 accessible form. The child’s understanding of the explanation given was recorded in a clinical file. Consent for treatment was obtained from one or both parents.

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

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

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. The policies included all policy-related criteria for this code of practice. The transfer policy was last reviewed in September 2016, and the transfer and discharge policies were reviewed in May 2016.

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: Admissions were on the basis of mental illness or mental disorder. An admission assessment was completed, which included medical and family history, presenting problem and mental health state, a risk assessment, and other relevant information. A full physical examination was undertaken. A key worker system was in place.

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

Discharge: There was one discharge reviewed on inspection. A discharge plan included documented communication with the relevant health practitioners and a follow-up plan. It did not include the estimated date of discharge or a reference to early warning signs of relapse and risks. There was no documentary evidence that the discharge meeting was attended by the resident, key worker, or relevant members of multi-disciplinary team held.

A discharge assessment addressed psychiatric and psychological needs, current mental state examination, social and housing needs, and informational needs. It did not include a comprehensive risk assessment and risk management plan. The discharge was coordinated by the key worker. A preliminary discharge summary was sent to the appropriate health practitioner within three days. A discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, and follow-up arrangements.

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

a) The discharge plan did not include an estimated date of discharge.

b) The discharge plan did not include a reference to early warning signs of relapse and risks.

c) There was no documentary evidence that the discharge meeting was attended by residents, key worker, relevant members of multi-disciplinary team, and resident’s representatives, where appropriate.

d) The discharge assessment did not include a comprehensive risk assessment and risk management plan.
### Regulation 7: Clothing

#### Report reference: Page 22

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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</table>
| **1.** Residents did not have access to emergency personal clothing that was appropriate and took account of their dignity and bodily integrity. 7(1) | **New** Corrective Action(s): Supply of stock is now in situ and is available to all patients who require same. Procument card to be requested to the Approved Centre from Senior Management  
Post-Holder(s) responsible: Mental Health Act Administrator / ADON | Quarterly audits will be completed | Achievable | 12 weeks |
|  | Preventative Action(s): Ensure adequate stock at all times and sufficient access to same  
Post-Holder(s) responsible: Mental Health Act Administrator / ADON | Quarterly audits will be completed | Achievable | 12 weeks |
## Regulation 9: Recreational Activities


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The approved centre did not provide access to recreational activities appropriate to the resident group profile.</td>
<td>New</td>
<td>Client feedback and satisfaction questionnaire suggestions to be sought from clients.</td>
<td>Funding being made available</td>
<td>Immediately</td>
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<td></td>
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<td>Attendance log to be reviewed</td>
<td>Staff resources within the unit.</td>
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<td>Increase our supply of recreational items within the High Obs Area.</td>
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<td></td>
<td>Preventative Action(s):</td>
<td>Seek Client feedback and satisfaction questionnaire on an ongoing basis</td>
<td></td>
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<td></td>
<td>Monitor compliance via attendance log and review feedback from clients</td>
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<tr>
<td></td>
<td>Post-Holder(s) responsible:</td>
<td>Attendance log to be reviewed</td>
<td></td>
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<tr>
<td></td>
<td><strong>CNM II &amp; CNM III in High Obs Unit</strong></td>
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# Regulation 13: Searches


<table>
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<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
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</table>
| 3. The request for consent and the received consent were not documented for every search of a resident and every property search (4). | Corrective Action(s): Search of Resident Policy to reviewed and and updated.  
Post-Holder(s) responsible:  
Nursing Education Committee                                                                     | Monthly audit to be completed in line with Best Practice Guidelines.    | Adherence and compliance by staff, visitors and residents                         | 4/6 weeks  |
| 4. General written consent was not sought for routine environmental searches, 13(5).       | Preventative Action(s):  
Following review of Search of Resident Policy, update all staff re same  
Post-Holder(s) responsible:  
Nursing staff & CNM III                                                                      | Regular update to all staff re adherence to policy.                    | Achievable                                                                            | 4/6 weeks  |
| 5. A written record of every search of a resident and every property search was not available, 13(9). | Corrective Action(s):  
Insert a summary page to the patient/resident information booklet.  
Post-Holder(s) responsible:  
CNM III and nursing staff                                                                    | Draft SOP to be implemented                                             | Achievable                                                                            | 4/6 weeks  |
| 6. A written record was not kept of all environmental searches, 13(9).                     | Preventative Action(s):  
Log will be maintained within the unit.  
Post-Holder(s) responsible:  
CNM III and nursing staff                                                                    | Draft SOP to be implemented                                             | Achievable                                                                            | 4/6 weeks  |
### Regulation 19: General Health

**Report reference: Page 35-36**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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</table>
| 7.  All six-monthly general health assessments inspected did not document waist circumference, 19 (1b). | Corrective Action(s): New 6 monthly physical template has been updated and is fully in implemented  
Post-Holder(s) responsible: **CNM III / Medical Staff**  
Preventative Action(s): Ongoing monitoring to ensure compliance  
Post-Holder(s) responsible: **CNM III / Medical Staff** | Audit to be completed on an ongoing basis to ensure compliance            | Achievable              | Completed                |
| 8.  For two residents on antipsychotic medication, there was no evidence to suggest prolactin levels were monitored annually, 19 (1b). | Corrective Action(s): New 6 monthly physical template has been updated and is fully in implementation  
Post-Holder(s) responsible: **Medical Staff**  
Preventative Action(s): New 6 monthly physical template has been updated and is fully in implementation  
Post-Holder(s) responsible: **Medical Staff** | Audit to be completed on an ongoing basis to ensure compliance            | Achievable              | Ongoing monitoring       | Completed                |
## Regulation 21: Privacy

*Report reference: Page 39*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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<tbody>
<tr>
<td>9. The registered proprietor did not ensure that the resident’s privacy and dignity was appropriately respected at all times as a clinical file and clinical documentation was on view to anyone passing the nurses office.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Corrective glass coating to be trialed around specific glass areas in nursing station to promote privacy. Signage to remind staff of their responsibility to ensure privacy of clinical files etc. within nursing stations Medical staff to be advised as part of their induction that the finding of this report. Same will be addressed at weekly teaching sessions and make medical staff fully aware of their responsibility</td>
<td>Glass coating to be provided Observation and feedback from both staff and patients Clinical Tutors to raise awareness to medical staff at each teaching session</td>
<td>Achievable</td>
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<td></td>
<td>Post-Holder(s) responsible: <strong>Medical Clinical Tutors</strong></td>
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<td>Preventative Action(s): Corrective contact to be trialled around specific glass areas in nursing station to promote privacy. Make staff aware of issue. <strong>Medical Clinical Tutors</strong></td>
<td>Monthly Audits in line with Best Practice Guidelines</td>
<td>Achievable</td>
</tr>
<tr>
<td>10. The registered proprietor did not ensure that the resident’s privacy and dignity was appropriately respected at all times as privately owned</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Additional screening is at quote stage and awaiting approval</td>
<td>Provisional of additional screening will improve privacy</td>
<td>Achievable</td>
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houses were overlooking the gardens.

<table>
<thead>
<tr>
<th><strong>Business Manager</strong></th>
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<tbody>
<tr>
<td><strong>Preventative Action(s):</strong></td>
<td></td>
<td><strong>Post-Holder(s) responsible:</strong></td>
<td><strong>Discussion</strong></td>
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<tr>
<td>Staff awareness re same until additional screening is in place</td>
<td>All Line Managers</td>
<td>Discussion will all staff re measures being taken</td>
<td></td>
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<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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<td>11. Medications causing allergies were not named, 23(1).</td>
<td>New</td>
<td>Corrective Action(s): Medical staff to be advised as part of their induction that the finding of this report must be implemented and made fully aware of their roles and responsibilities</td>
<td>Audits in line with Best Practice Guidelines</td>
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<td></td>
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<td>Post-Holder(s) responsible: <strong>Medical Clinical Tutors</strong></td>
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<td></td>
<td></td>
<td>Preventative Action(s): Medical staff to be advised as part of their induction of their roles and responsibilities</td>
<td>Audits in line with Best Practice Guidelines</td>
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<td>Post-Holder(s) responsible: <strong>Medical Clinical Tutors</strong></td>
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<tr>
<td>12. Route of medication was not documented 23(1)</td>
<td>New</td>
<td>Corrective Action(s): Medical staff to be advised as part of their induction that the finding of this report must be implemented and made fully aware of their roles and responsibilities</td>
<td>Audits in line with Best Practice Guidelines</td>
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<td></td>
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<td>Post-Holder(s) responsible: <strong>Nursing Education Committee</strong></td>
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</table>
13. Not all medications administered to the resident recorded, 23(1).
14. Withholding of medication was not documented in the clinical file, 23(1).

<table>
<thead>
<tr>
<th></th>
<th>Preventative Action(s):</th>
<th>Achievable</th>
<th>4 months</th>
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<tbody>
<tr>
<td></td>
<td>Update of medication management policy</td>
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<td></td>
<td>Post-Holder(s) responsible: Nursing Education Committee</td>
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<thead>
<tr>
<th></th>
<th>Corrective Action(s):</th>
<th>Achievable</th>
<th>2 weeks</th>
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<tr>
<td></td>
<td>Nursing staff have been notified to update their knowledge on the medication management. Summary sheet is being drafted and circulated to all nursing staff to read and sign.</td>
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<td>Post-Holder(s) responsible: CNM III</td>
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<tr>
<td></td>
<td>Preventative Action(s): All staff have been notified about their roles and responsibilities</td>
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<td></td>
<td>Post-Holder(s) responsible: CNM III</td>
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</table>

15. The policy did not reflect legislative changes to the Mental Health Act 2001 in 2015, which removed reference to ‘unwilling’ in relation to consent, 23(1).

<table>
<thead>
<tr>
<th></th>
<th>Corrective Action(s): Medication Management Policy is under review</th>
<th>Achievable</th>
<th>3 / 4 months</th>
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<tbody>
<tr>
<td></td>
<td>Review policy Quarterly audit programme using best practice checklist as part of best practice guidelines is carried out to ensure compliance</td>
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<tr>
<td>Action(s):</td>
<td>Preventative Action(s): Review Policy reflect legislative changes to same</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
<td>Nursing Education Committee</td>
<td></td>
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<tr>
<td>Achievement</td>
<td>Quarterly audit programme using best practice checklist as part of best practice guidelines is carried out to ensure compliance</td>
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<tr>
<td>Achievable</td>
<td>3 / 4 months</td>
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</table>
### Area(s) of non-compliance

16. Not all health care professionals were trained in Basic Life Support, Fire Safety and the management of violence and aggression 26(4)
17. Not all health care professionals were trained in the Mental Health Act 2001, 26(5)

### Reoccurring Corrective Action(s):

- **Specific:**
  - Corrective Action(s):
    - Full mandatory training schedule has been circulated to all staff
  - Post-Holder(s) responsible: **All Line Managers**

- **Measureable:**
  - Nurse Proactive Development Co-coordinator is now in post within the service. Quarterly reports will be provided to the local operational and clinical groups to monitor compliance with mandatory training.

- **Achievable / Realistic:**
  - Current vacancies and availability of instructors will have an impact on the release instructors and number of attendees

- **Time-bound:**
  - Quarterly

### Preventative Action(s):

- **Specific:**
  - Preventative Action(s):
    - Notification to all staff to complete online HSE training, which provides full certification for staff members
  - Post-Holder(s) responsible: **All Line Managers**

- **Measureable:**
  - Relevant line managers to ensure that all their staff are fully in adherence.

- **Achievable:**
  - Achievable

- **Time-bound:**
  - 4 / 6 weeks
## Regulation 27: Maintenance of Records

*Report reference: Page 49-50*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 18. Records and reports were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. | **Corrective Action(s):**
Summary sheet to be circulated to all staff within the unit to advise individuals of their responsibilities with regard to this regulation.
All staff to read and sign sheet to confirm same
Post-Holder(s) responsible: **All Line Managers** | Ongoing audit re management of records.                                                      | Achievable   | 4 weeks                |
| 19. A number of resident records did not detail volume numbers adequately.              | **Preventative Action(s):**
Weekly check of notes for compliance with regard to record management
Post-Holder(s) responsible: **CNM II**                                                       | Ongoing audit re management of records.                                                      | Achievable   | 4 Weeks                |
| 20. Records were not maintained in good order due to loose pages.                      |                                                                                                   |             |                        |            |
| 21. Not all entries noted the time using the 24-hour clock.                             |                                                                                                   |             |                        |            |
| 22. Where an error was made on an MPAR the protocol for correcting the error was not adequately followed. |                                                                                                   |             |                        |            |
| 23. Resident records were not reflective of the residents’ current status (voluntary or involuntary). | **Corrective Action(s):**
Roles and responsibility to be clearly highlighted as to the residents current status throughout the clinical file.
Post-Holder(s) responsible: **All Line Managers** | Ongoing monthly audits                                                                 | Achievable   | 2 Weeks                |
| 24. There was no resident identifier detailed on one clinical file.                   | **Preventative Action(s):**
Highlight the roles and responsibilities to all staff
Post-Holder(s) responsible: **All Line Managers** | Ongoing monthly audits                                                                 | Achievable   | 2 weeks                |
## Regulation 28: Register of Residents

*Report reference: Page 51*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 25. The Register was incomplete and did not include all elements as per schedule 1,(2), Specifically, it did not record:  
  • Diagnosis on admission or provisional diagnosis where diagnosis was not available.  
  • Diagnosis on discharge. | Corrective Action(s):  
  The specific details for the provisional diagnosis on admission and discharge has been included on the assessment pro forma for admissions  
  Post-Holder(s) responsible: **NCHD’s** | A monthly report will be provided on the compliance levels of recording provisional admission diagnosis | Achievable | Ongoing |
|  | Preventative Action(s):  
  ECD to discuss with consultants re same  
  Post-Holder(s) responsible: **ECD** | A monthly report will be provided on the compliance levels of recording provisional admission diagnosis | Achievable | Ongoing |
### Code of Practice: Physical Restraint


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td><strong>26.</strong> In two cases, the registered medical professional did not complete a medical examination within three hours of the end of the episode, 5.4.</td>
<td>New</td>
<td>Corrective Action(s): Summary sheet for medical staff and nursing staff being developed</td>
<td>Monthly audit in line with best practice guidelines</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:  <strong>Medical &amp; Nursing staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Summary sheet for medical staff and nursing staff being developed</td>
<td>Monthly audit in line with best practice guidelines</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:  <strong>Medical &amp; Nursing staff</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>27.</strong> In no case was there documentary evidence in the clinical file that the resident was informed of reasons for, likely duration of, or circumstances leading to discontinuation, 5.8</td>
<td>New</td>
<td>Corrective Action(s): Checklist will be developed to ensure compliance with all areas in relation the use of physical restraint</td>
<td>Monthly audit in line with Best Practice Guidelines</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:  <strong>Medical &amp; Nursing staff within Approved Centre</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Develop checklist for implementation</td>
<td>Monthly audit in line with Best Practice Guidelines</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible:  <strong>Medical &amp; Nursing staff within Approved Centre</strong></td>
<td></td>
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</tr>
</tbody>
</table>
28. In one of the three cases, the resident’s representative was not informed of the use of physical restraint, as this was not recorded in the clinical file 5.9(a).

**New**

Corrective Action(s):
- Checklist will be developed to ensure compliance with all areas in relation the use of physical restraint

Post-Holder(s) responsible:
- Medical and nursing staff

Preventative Action(s):
- Checklist to be developed

Post-Holder(s) responsible:
- Medical and nursing staff

Monthly audit in line with Best Practice Guidelines. Achievable 6 weeks

29. There was no documentary evidence that residents were afforded an opportunity to discuss the episode with members of their multi-disciplinary team, 7.2.

30. There was no evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days, 9.3.

**New**

Corrective Action(s):
- Checklist will be developed to ensure compliance with all areas in relation the use of physical restraint

Post-Holder(s) responsible:
- CNM III

Preventative Action(s):
- Checklist will be developed to ensure compliance with all areas in relation the use of physical restraint

Post-Holder(s) responsible:
- CNM III

Monthly audit in line with Best Practice Guidelines. Achievable 4 weeks
<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>31. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5(b).</td>
<td>Corrective Action(s): At all times the admission of a child will only be considered when there is no other option available. Post-Holder(s) responsible: ECD</td>
<td>Monthly reports will be provided in relation to admission of a child to management team</td>
<td>Difficulties with access to beds in child admission units with the Approved Centre having no option but to admit re lack of beds available.</td>
<td>April 2019</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): In the even when necessary to admit a child, the decision to admit will be discussed with the ECD with a discharge plan in place to minimise the length of admission Post-Holder(s) responsible: ECD</td>
<td>Monthly reports will be provided in relation to admission of a child to management team</td>
<td>Difficulties with access to beds in child units. With Approved Centre having no option but to admit re lack of beds available.</td>
<td>April 2019</td>
</tr>
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<td>Area(s) of non-compliance</td>
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<td>32. The discharge plan did not include an estimated date of discharge.</td>
<td>Corrective Action(s): ECD to discuss with consultants re same. Post-Holder(s) responsible: ECD/Consultants</td>
<td>Highlight at weekly teaching sessions</td>
<td>Achievable</td>
<td>2/4 months</td>
</tr>
<tr>
<td>33. The discharge plan did not include a reference to early warning signs of relapse and risks.</td>
<td>Preventative Action(s): ECD to discuss with consultants / psychiatry. Post holder ECD</td>
<td>Monthly audit in line with Best Practice Guidelines.</td>
<td>Achievable</td>
<td>2/4 months</td>
</tr>
<tr>
<td>34. There was no documentary evidence that the discharge meeting was attended by residents, key worker, relevant members of multi-disciplinary team, and resident’s representatives, where appropriate.</td>
<td>New</td>
<td></td>
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<td>35. The discharge assessment did not include a comprehensive risk assessment and risk management plan.</td>
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