# O'Casey Rooms, Fairview Community Unit

**ID Number:** AC0083

## 2018 Approved Centre Inspection Report (Mental Health Act 2001)

O'Casey Rooms, Fairview Community Unit
Griffith Court
Philipsburgh Avenue
Dublin 3

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

**Most Recent Registration Date:**
8 March 2017

**Conditions Attached:**
Yes

**Registered Proprietor:**
HSE

**Registered Proprietor Nominee:**
Ms Anne Marie Donohue, General Manager, Mental Health Services, CHO DNCC

**Inspection Team:**
Martin McMenamin, Lead Inspector
Dr Enda Dooley MCRN004155
Noeleen Byrne

**Inspection Date:**
12 – 15 June 2018

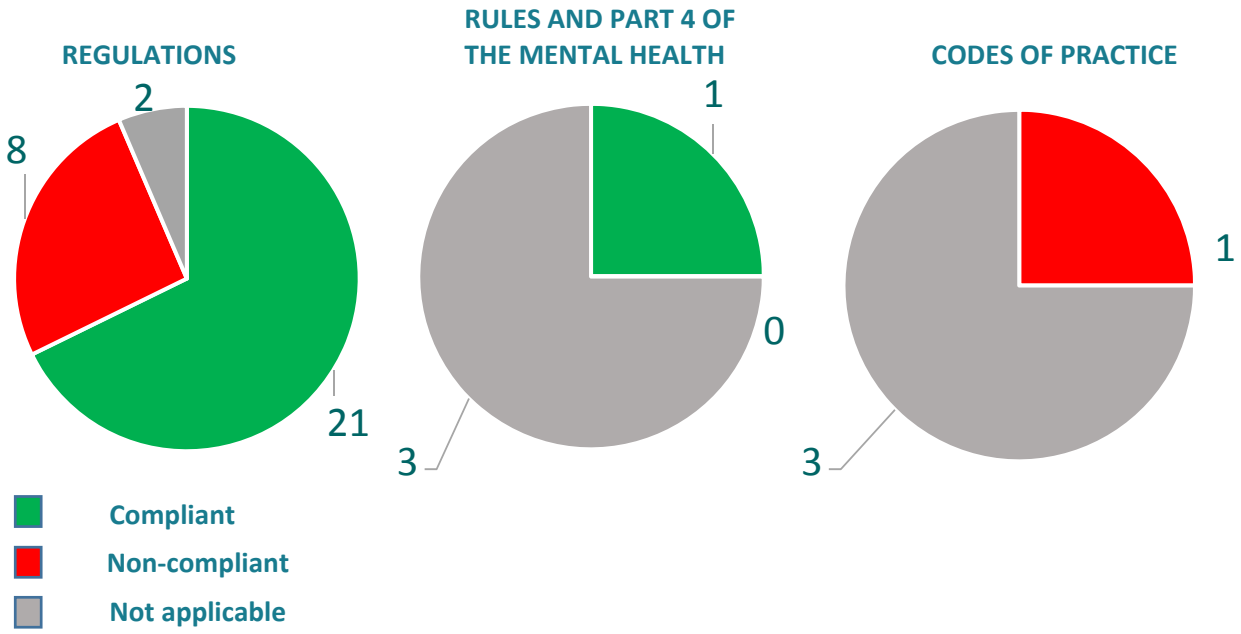
**Inspection Type:**
Unannounced Annual Inspection

**Previous Inspection Date:**
11– 13 April 2017

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

**Date of Publication:**
17 January 2019

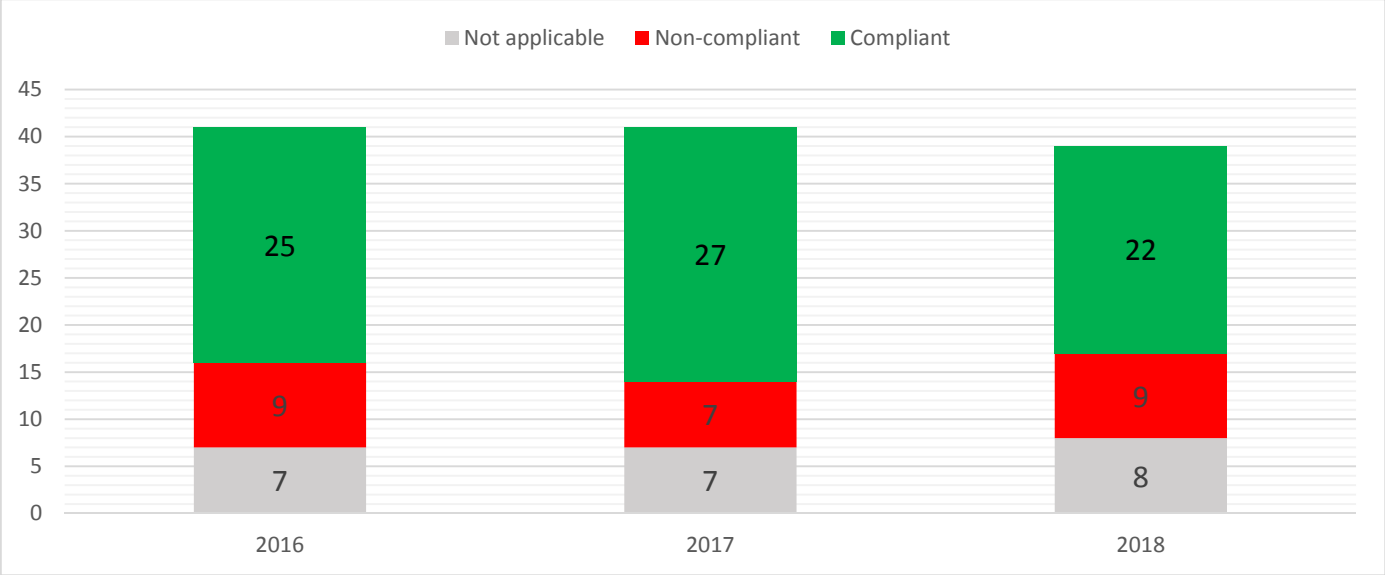
## 2018 COMPLIANCE RATINGS



# RATINGS SUMMARY 2016 – 2018

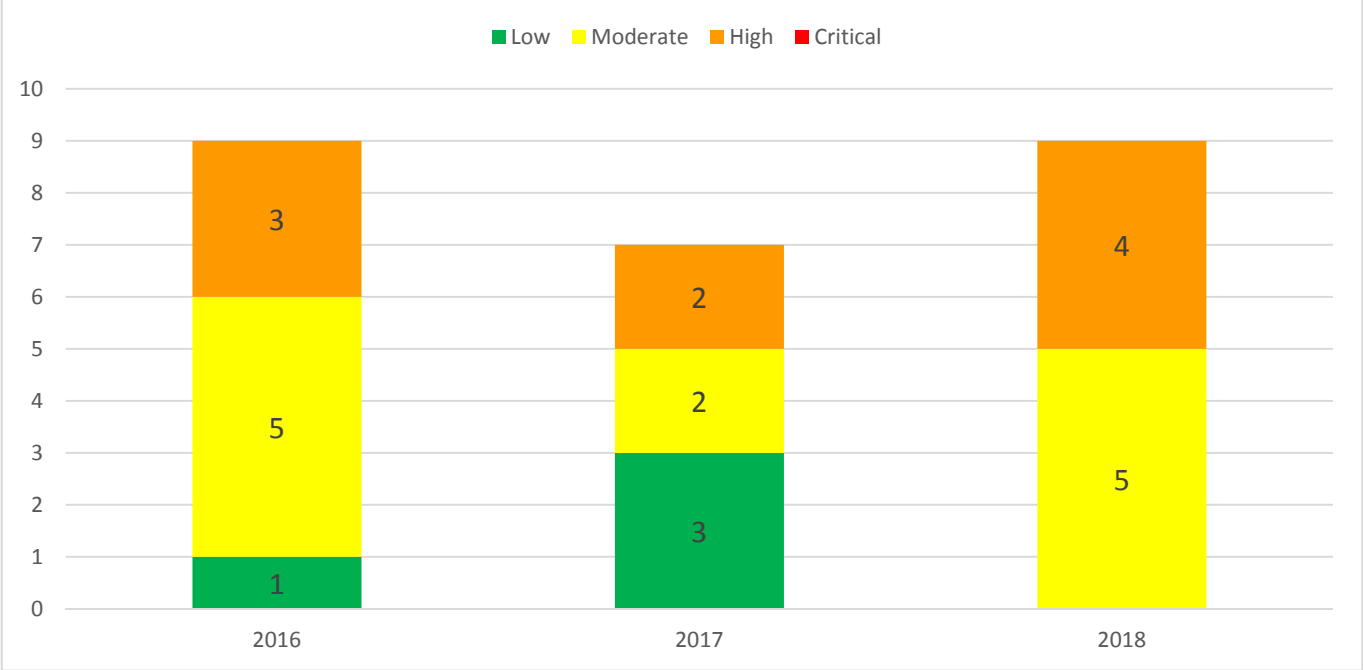
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

## Chart 1 – Comparison of overall compliance ratings 2016 – 2018




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

## Chart 2 – Comparison of overall risk ratings 2016 – 2018



# Contents

# 1.0 Introduction to the Inspection Process

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

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

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

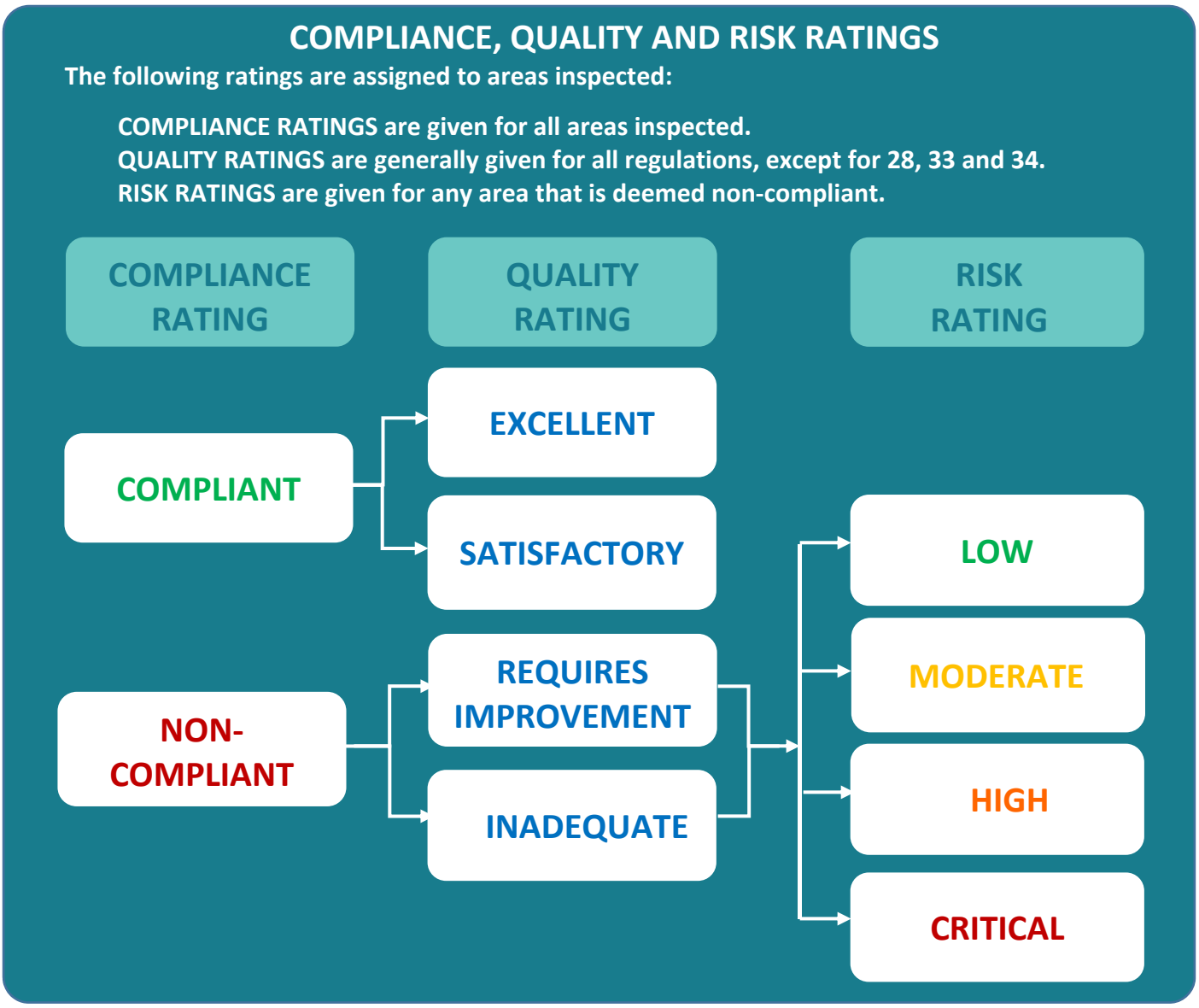
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.




The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

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

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

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

# 2.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

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

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

## In brief

O'Casey Rooms was on the first floor of a Community Nursing Unit owned by the Sisters of Charity, St. Vincent's Hospital, Fairview. Residents in O'Casey Rooms were under the care of either the Rehabilitation Team, which had access to six beds, or the Mental Health Service of Older Persons/Psychiatry of Later Life Team, which had access to 18 beds. It was an unsuitable premises for both rehabilitation and the care of elderly residents. Most of the residents had been in residential mental health services for many years and as they aged, their care and treatment requirements were now significantly focused on physical, palliative and end of life care. Historically, a number of residents had come from St. Ita's Hospital, where they had been resident for many years. It was apparent that for most of the residents the approved centre was their home.

The approved centre's compliance with Rules, Regulations and Codes of Practice in 2018 was 70%, which did not differ significantly from compliance in 2016 (74%) and showed a deterioration from 2017 (79%). Two conditions were attached to the registration of the approved centre, prohibiting admissions to the approved centre and that a plan for closure must be submitted to the Mental Health Commission. Compliance with five regulations was rated excellent.

## Safety in the approved centre

Catering areas and associated catering and food safety equipment were appropriately cleaned but food safety audits had not been completed periodically. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, prevention and management of aggression and violence and the Mental Health Act 2001. Individual risk assessments were completed prior to and during mechanical restraint, at admission to identify individual risk factors, at resident transfer, at resident discharge, and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults within the approved centre were implemented as required.

## Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan but there was no evidence of collaboration with residents or their families. There was excellent end of life care provided which was respectful of residents' dignity and needs. There was a good range of therapeutic programmes that met the assessed needs of the

residents. The residents' general health was assessed and monitored, six monthly physical examinations were carried out, and residents had access to general medical care when necessary. Mechanical restraint in the form of lap belts was carried out to prevent enduring risk of harm to residents and its use was compliant with the Rule governing its use.

## Respect for residents' privacy, dignity and autonomy

It was evident that residents' privacy and dignity was respected throughout the approved centre. There were private spaces for residents to receive visitors and there was unrestricted access to external communication. Residents wore their own clothes.

## Responsiveness to residents' needs

There was an excellent range of recreational activities available. 'A Breath of Fresh Air' initiative was set up by nursing staff to encourage staff and families to promote access to the outdoor areas of the unit and the locality. Spiritual care was provided where requested by the resident. Residents had access to their property and valuables, which were safely stored. Written information was provided about the approved centre but there was no information about diagnoses or medication. There had been no complaints from residents or their families since the previous inspection. There was a complaints process in place.

Appropriate signage and sensory aids such as pictorial, written, braille, and photographic prompts were provided for resident orientation needs. The communal rooms and areas provided such as the dining room, sitting room, and outdoor spaces were all too small to accommodate the number and mix of residents using them and residents did not have adequate space to move about. Residents did not have sufficient access to outdoor spaces including external gardens; access was not possible unless staff were specifically available to accompany residents outside. There was a small, inadequately designed outdoor space on the first floor. The approved centre was clean, hygienic, and free from offensive odours. It was kept in a good state of repair inside and outside. There was no programme of routine, general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There were long delays in addressing of maintenance issues which resulted in maintenance issues becoming urgent.

## Governance of the approved centre

O'Casey Rooms were under the governance and management of North Dublin Mental Health Services (NDMHS) and had been renting O'Casey Rooms since 2011 from the Sisters of Charity. NDMHS was part of Community Healthcare Organisation (CHO) 9 area, and responsibility for the management of O'Casey Rooms was designated to the senior management team of NDMHS.

The NDMHS management team meetings took place at least once a month. Quality and safety issues, including serious incidents, were reviewed at the management team meetings. These structures were supported by Individual Care Planning Committee, Quality & Patient Safety, Health & Safety, Drug and Therapeutic and Emergency Planning Committees. It was also clear from the interviews with Heads of Service, and in reviewing the risk assessments, that the service had robust risk assessment, management and review processes in place.

The NDMHS Quality and Patient Safety Committee met approximately bi-monthly. Issues discussed included serious incidents, training, risk registers, infection prevention and control, and compliance. The nursing

management locally had also introduced a ‘safety pause’ initiative with multi-disciplinary involvement with the aim of further strengthening clinical governance within the approved centre. There was no emergency/evacuation plan in place which specified the required response by approved centre staff to possible emergencies.

O’Casey Rooms would benefit from clearer and more effective communications pathways and engagement with St. Vincent’s Hospital in terms of shared estate management, maintenance management and in terms of planning for emergencies and evacuation plans with the other tenants who share the building. This would also enable the opportunity to discuss the more effective use of existing resources, for the benefit of all healthcare providers within the building.

# 3.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. 'A Breath of Fresh Air' initiative was set up by nursing staff to encourage staff and families to promote access to the outdoor areas of the Unit and the locality.

2. Introduction of a large interactive touch screen with internet access and full HD display for a variety of resident led activities such as 'armchair travelling', music and film reminiscence, gaming, quizzes and meditation.

3. Social Work led group - Promoting Wellbeing 'Feelings Group'.

4. Introduction of a Musical Reminiscence Group facilitated by Psychology, Social Work and Nursing.

5. Implementation of a 'Cognitive Stimulation Informed' Therapy Group co-facilitated by Social Work and Psychology.

6. 'Forever Autumn' was introduced to enhance patient safety and minimise falls and falls related injuries.

7. Staff had also introduced a daily safety pause comprised of members of the multi-disciplinary team.

8. An O'Casey Working Group was formed to scope the needs and provision of a new modern residential accommodation unit.

9. The approved centre had also introduced the HSE communication initiative 'Hello, my name is……'

10. Introduction of Pool Activity Level (PAL) Assessment and guidance for residents using the multi-sensory room.

# 4.0 Overview of the Approved Centre

## 4.1 Description of approved centre

The approved centre known as O'Casey Rooms was on the first floor of a Community Nursing Unit owned by the Sisters of Charity, St. Vincent's Hospital, Fairview. It was located in a residential area off Philipsburgh Avenue and at the rear of St. Vincent's Hospital. O'Casey Rooms were under the governance and management of North Dublin Mental Health Services (NDMHS) and had been renting this first-floor space since 2011 from the Sisters of Charity.

Residents in O'Casey Rooms were under the care of either the Rehabilitation Team, which had access to six beds, or the Mental Health Service of Older Persons/Psychiatry of Later Life Team, which had access to 18 beds. Most of the residents had been in residential mental health services for many years and as they aged, their care and treatment requirements were now significantly focused on physical, palliative and end of life care. Historically, a number of residents had come from St. Ita's Hospital: Unit 8, and Willowbrook. There were seven sector mental health teams under the management of NDMHS: Kilbarrack East and West, Darndale, Coolock, Balbriggan, Swords and Killester.

Access to the approved centre was by a stairs or lift. Accommodation comprised of 17 en suite bedrooms, two double bedrooms, and one four-bed dormitory. Each room or accommodation had been repainted and personalised to the residents' tastes and preference. It was apparent that for most of the residents the approved centre was their home.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***25*** |
| **Total number of residents** | **24** |
| Number of detained patients | 0 |
| Number of wards of court | 3 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 24 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 4.2 Conditions to registration

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

**Condition 1:** The approved centre shall implement a plan to close O'Casey Rooms, Fairview Community Unit. The approved centre shall provide a progress update on the closure plan to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 2:** Effective 1st January 2018, the Mental Health Commission prohibits any direct admission or transfers of residents to the approved centre, with the exception of current residents that are transferred back to the approved centre following the receipt of care and treatment from an approved centre, hospital or other place.

## 4.3 Reporting on the National Clinical Guidelines

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

## 4.4 Governance

The O'Casey Rooms approved centre was part of the North Dublin Mental Health Service (NDMHS). NDMHS was part of Community Healthcare Organisation (CHO) 9 area, and responsibility for the management of O'Casey Rooms was designated to the senior management team of NDMHS. There was an organisational chart and clear governance structures and processes in place reflecting the NDMHS structures.

The NDMHS management team meetings took place at least once a month. Minutes of the management team meetings for the previous twelve months were provided to the inspection team. The management working team met approximately six times a month. These meetings addressed clinical reviews, one meeting focused on compliance issues and one dealt with business issues. Quality and safety issues, including serious incidents, were reviewed at these meetings. These structures were supported by Individual Care Planning, Quality & Patient Safety, Health & Safety, Drug and Therapeutic, and Emergency Planning Committees. It was also clear from the interviews with Heads of Service, and in reviewing the risk assessments, that the service had robust risk assessment, management and review processes in place.

The NDMHS Quality and Patient Safety Committee met approximately bi- monthly. Minutes of the previous year's meetings were provided to the inspection team and issues discussed included serious incidents, training, risk registers, infection prevention and control, and compliance. The nursing management locally had also introduced a 'safety pause' initiative with multi-disciplinary involvement with the aim of further strengthening clinical governance within the approved centre.

The premises was not fit for purpose as an approved centre in the long term and, as such, the Mental Health Commission attached a condition prohibiting new admissions to the approved centre. Managing the approved centre, in the context of the conditions attached by the Mental Health Commission to its registration, has presented a challenge to the service's care pathways. The loss of admission facilities in the approved centre has had a knock on effect on other approved centres and community teams access to beds. The service had set in place clear structured processes to offset these, and a specific forum to address future accommodation needs had been initiated.

In the interim, O'Casey Rooms would benefit from clearer and more effective communications pathways and engagement with St. Vincent's Hospital in terms of shared estate management, maintenance management and in terms of planning for emergencies and evacuation plans with the other tenants who share the

building. This would also enable the opportunity to discuss the more effective use of existing resources, for the benefit of all healthcare providers within the building.

## 4.5 Use of restrictive practices

Although all the residents were voluntary, the entrance door into the approved centre was by requested entry, or swipe card. This was in consideration of the assessed clinical needs of the residents and in ensuring the safeguarding of residents. However, one or two residents would benefit from having their own access control.

In relation to resident monies, access to resident money was only available on days where there was a clinical nurse manager 2 or assistant director of nursing on duty who was in receipt of a required key. Restriction on residents' access to their own funds was further compounded by the fact that the Accounts office was only open on Wednesday and Thursday of each week.

# 5.0 Compliance

## 5.1 Non-compliant areas on this inspection

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

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2016 | | Compliance/Risk Rating 2017 | | Compliance/Risk Rating 2018 | |
|---|---|---|---|---|---|---|
| Regulation 15: Individual Care Plan | ✓ | | ✗ | Low | ✗ | High |
| Regulation 18: Transfer of Residents | ✗ | High | ✓ | | ✗ | Moderate |
| Regulation 20: Provision of Information to Residents | ✗ | Moderate | ✓ | | ✗ | Moderate |
| Regulation 22: Premises | ✗ | High | ✗ | High | ✗ | High |
| Regulation 26: Staffing | ✗ | Moderate | ✗ | High | ✗ | High |
| Regulation 27: Maintenance of Records | ✗ | Moderate | ✗ | Moderate | ✗ | Moderate |
| Regulation 28: Register of Residents | ✗ | Moderate | ✓ | | ✗ | Moderate |
| Regulation 32: Risk Management Procedures | ✓ | | ✗ | Moderate | ✗ | High |
| Code of Practice: Admission Transfer and Discharge to and from an Approved Centre | ✗ | High | ✗ | Low | ✗ | Moderate |

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in **Appendix 1** of the report.

## 5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

| Regulation |
|---|
| Regulation 5: Food and Nutrition |
| Regulation 7: Clothing |
| Regulation 9: Recreational Activities |
| Regulation 11: Visits |
| Regulation 14: Care of the Dying |

## 5.3 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre did not admit children, this regulation was not applicable. |
| Regulation 25: Use of Closed Circuit Television | As CCTV was not in use in the approved centre, this regulation was not applicable. |
| Rules Governing the Use of Electro-Convulsive Therapy | As the approved centre did not provide an ECT service, this rule was not applicable. |
| Rules Governing the Use of Seclusion | As the approved centre did not use seclusion, this rule was not applicable. |
| Part 4 of the Mental Health Act 2001: Consent to Treatment | As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable. |
| Code of Practice on the Use of Physical Restraint in Approved Centres | As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre did not admit children, this code of practice was not applicable. |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | As the approved centre did not provide an ECT service, this code of practice was not applicable. |

# 6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The 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 six residents who provided information on their lived experiences within the Unit. All residents had a key nurse and all liked their bedroom facilities and enjoyed the food. Residents were complimentary of their care and treatment in the approved centre. All of these residents knew their care planning coordinator and the other staff members directly involved in their individual care. One family member completed the service user experience questionnaire and gave a high rating for their overall experience of care and treatment by the approved centre.

# 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
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Acting/ Clinical Nurse Manager 2
- Senior Psychologist
- Clinical Psychologist
- Social Worker
- Occupational Therapist
- Executive Clinical Director
- Consultant Psychiatrist
- Head of Service, NDMHS
- Area Lead for Service User Engagement
- Service Manager

Acknowledgement was given to the clinical heads of discipline who had made themselves available to speak with the inspectors and those that facilitated the inspection process. The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

A short discussion ensued in relation to the conditions attached to the Approved Centre's registration with the Mental Health Commission. Pending the successful approvals and funding for a new greenfield site, the service identified a need to plan for an interim solution in terms of the approved centre's current resident capacity, as all other variables had been explored without success. The Executive Clinical Director indicated that communication with the Mental Health Commission regarding the conditions was likely in due course. An explanation of the likely period of time of when the draft report would be issued was also given.

# 8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

**Evidence of Implementation:** There were a minimum of two person-specific resident identifiers, appropriate to the resident group profile and individual residents' needs. The preferred identifiers used for each resident were detailed within residents' clinical files. Name and date of birth were used for administering medication. In addition, a photo of the residents was maintained on the medication trolley. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or a similar name.

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

## Regulation 5: Food and Nutrition

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

**Evidence of Implementation:** Menus were reviewed by an external dietician. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. There was a choice of two meals at lunch and tea-time. Meals were presented in an attractive form. Hot drinks were provided to residents with all meals and on request by staff. Cold drinks were readily available to residents.

There was a water dispenser in the dining room, which provided residents with a safe supply of fresh drinking water. A choice of hot meals was provided daily. An evidence-based nutrition screening tool, the Malnutrition Universal Screening Tool was available for use. Weight charts were maintained as appropriate. Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian as required.

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

## Regulation 6: Food Safety

**COMPLIANT**

**Quality Rating** **Satisfactory**

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to food safety, which was last reviewed in March 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. Not all relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food did not have up-to-date training in food safety commensurate with their role.

**Monitoring:** Food safety audits had not 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 not been completed to identify opportunities to improve food safety processes.

**Evidence of Implementation:** The kitchen had an appropriate hand washing area. Staff had access to appropriate Personal Protective Equipment. Food was not prepared in the approved centre; only a cook-chill process was operated. Main meals were provided by St Ita's Hospital catering services. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned. Residents were provided with adequate supplies of appropriate cutlery and crockery.

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

## Regulation 7: Clothing

**COMPLIANT**

**Quality Rating** **Excellent**

The registered proprietor shall ensure that:

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to residents' clothing, which was last reviewed in January 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

**Monitoring:** The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes at the time of inspection.

**Evidence of Implementation:** Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Some spare nightclothes were kept on the unit. Clothes could be purchased in nearby shops if necessary. Residents had an adequate supply of individualised clothing.

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

## Regulation 8: Residents' Personal Property and Possessions

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in January 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. Not all relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

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

**Evidence of Implementation:** On admission, staff in the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's ICP and was available to the resident. Residents were supported to manage their own property.

There was a safe in the nursing office. However, it could only be accessed when there was a Clinical Nurse Manager 2 (CNM2) or Assistant Director of Nursing (ADON) on duty. The accounts office was only open on Wednesday and Thursday. If a resident received money from a family member, or a gift, it could only be placed in the accounts office on these days. A new system was put in place where the key could only be held by the CNM2 or ADON. A notice also said that the accounts office was only open on Wednesday and Thursday between 9.30 and 13.00.

**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, monitoring, and evidence of implementation pillars.**

## Regulation 9: Recreational Activities

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in August 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 recreational activities, as set out in the policy.

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

**Evidence of Implementation:** The approved centre provided access to recreational activities appropriate to the resident group profile. Bingo took place twice a week, as well as informal music groups. The approved centre recently acquired a 70-inch interactive touch screen known as “Clever Touch”. This interactive touch screen operated like a giant tablet device. It included an electronic whiteboard where word wheel and crosswords from the daily newspaper could be accessed by residents. Residents watched concerts on a digital music channel. Music quizzes were arranged on screen and the music through a Bluetooth device. “Armchair Travel” took place each week to a different destination. Other activities included pampering sessions, hair and beauty, prayers, knitting and reading.

Residents went on trips at weekends. This was staff dependant. There were signs and visual displays appropriate to individual resident needs. At monthly meetings, residents discussed and suggested improvements to recreational activities. Staff assessed resident recreational needs according to the resident profile and previous attendance. A downstairs garden could be accessed and residents were brought for walks and outings. For some residents the outdoor space was only accessible with staff accompaniment.

**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* under the processes, training and education, monitoring, and evidence of implementation pillars.**

## Regulation 10: Religion

**COMPLIANT**

**Quality Rating** **Satisfactory**

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 January 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for identifying residents' religious beliefs.

**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:** At the time of inspection, no resident had any specific religious requirements in relation to care provision. Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Mass was held weekly within the approved centre for residents who were unable to go out. A list of chaplains was documented on the ward notice board. Where staff resources allowed, residents were facilitated in attending local religious services of their choice. Residents were free to partake in or abstain from religious practice based on personal preference.

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

## Regulation 11: Visits

**COMPLIANT**

**Quality Rating** **Excellent**

(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. The policies 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 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 displayed throughout the unit and were included in the resident information booklet. The approved centre was open to visitors with the exception of meal times. The unit had a number of visiting rooms together with a seating area in the foyer, external to the unit. Visits could also occur in resident bedrooms. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety. Requirements for visiting children were documented in the information booklet and on notices within the unit. The visiting rooms and additional visiting areas were suitable for visiting children.

**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* under the processes, training and education, monitoring, and evidence of implementation pillars.**

## Regulation 12: Communication

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in October 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the assessment of resident communication needs.

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

**Monitoring:** Documented analysis had been completed to identify ways of improving communication processes.

**Evidence of Implementation:** Residents could use mail, fax, telephone, and internet if they wished, unless otherwise risk assessed with due regard to their well-being, safety, and health. At the time of the inspection, no resident was assessed as being at risk in relation to their communications, and therefore no resident communication was being examined by the clinical director or a designated senior staff member.

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

## Regulation 13: Searches

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in October 2016. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

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

**Monitoring:** As no searches had been conducted since the last inspection, the approved centre was not inspected against the evidence of implementation pillar for this regulation.

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

**The approved centre was compliant with this regulation.**

## Regulation 14: Care of the Dying

**COMPLIANT**

**Quality Rating** **Excellent**

(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. The policies were last reviewed in March 2018. 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.

**Monitoring:** End of life care provided to residents was systematically reviewed to ensure section two of the regulation had been complied with. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

**Evidence of Implementation:** Since the last inspection there were three residents died. The clinical file relating to one resident was reviewed. The resident was nursed in a single room when nearing end of life. Discussions and consent regarding advance directives relating to organ donation and Do Not Attempt Resuscitation orders and associated documentation, were evidenced in the clinical file. The unit had access to palliative care provision. The clinical file indicated that good practices were maintained in pain management, pastoral care, privacy and family support. All deaths of residents were notified to the Mental Health Commission within the required 48-hour timeframe.

**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* under the processes, training and education, monitoring, and evidence of implementation pillars.**

## Regulation 15: Individual Care Plan

**NON-COMPLIANT**

**Quality Rating** Requires Improvement
**Risk Rating** HIGH

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in October 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. 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:** All residents lived in the approved centre on a long term basis. The ICP identified appropriate goals for the resident. ICPs were stored within the clinical file, were identifiable and uninterrupted. ICPs were not amalgamated with progress notes. The ICP identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for delivering the care and treatment. The ICP identified the resources required to provide the care and treatment identified.

The ICP was reviewed by the MDT every three months. Involvement of the resident in the process was unclear. The ICP was updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. ICPs did not include an individual risk management plan. There was no documentary evidence to indicate that the resident had attended ICP review or was offered a copy of their ICP. When a resident declined or refused a copy of their ICP this was not recorded.

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

a) **The ICP process and documentation did not confirm that the process was undertaken as far as practicable in consultation with each resident. It was unclear whether the resident or key-worker attended the ICP review process.**
b) **In a number of cases the review documentation was incomplete regarding whether the resident was offered a copy, or if not, why not.**

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre's policy in relation to therapeutic services and programmes was a generic North Dublin Mental Health Services policy. Dated January 2017, it did not specifically reference the approved centre but did include the requirements of the JSF.

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

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

**Evidence of Implementation:** Therapeutic services and programmes provided by the approved centre were extensive, evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents.

Therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Activity groups included; psychology, multi-sensory, Sonas, mindfulness, relaxation, 'Let's Have Fun', exercise, pamper, and a feelings group.

Adequate and appropriate resources and facilities were not available to provide the therapeutic services and programmes. While there were dedicated staff to facilitate activities, and there were dedicated rooms for the delivery of therapeutic activities, the actual space used for this purpose was too small and inadequate.

Given the lack of space, there was a risk that some activities might not be available to residents leading to a degree of rationing given the lack of available space. There could be more activities if communal rooms and activity rooms were bigger, and thus more residents could attend, engage, and avail of more activities if required. Generally, therapeutic services and programmes needed were provided internally. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents' clinical files.

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

## Regulation 18: Transfer of Residents

**NON-COMPLIANT**

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

(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 January 2016. 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 the transfer of residents, as set out in the policy.

**Monitoring:** A log of transfers was maintained. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

**Evidence of Implementation:** The clinical file of one resident who had been transferred from the approved centre was examined. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks. There was a record to indicate the resident's accompaniment requirements on transfer. Documented consent of the resident to the transfer was available.

As assessment of the resident was completed prior to the transfer, including a risk assessment relating to the transfer and the resident's needs. The assessment and results were not provided to the receiving facility. Written information including a letter of referral, list of current medications, resident transfer form, and required medication for the resident during the transfer process was not routinely provided as part of the transfer documentation. Copies of all records relevant to the resident transfer were not retained in the resident's clinical file.

A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were not retained in the residents' clinical file.

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

## Regulation 19: General Health

**COMPLIANT**

**Quality Rating** **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

### INSPECTION FINDINGS

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

- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan (ICP).

**Training and Education:** Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

**Evidence of Implementation:** The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED) at all times. Registered medical practitioners assessed residents' general health needs on admission and on an ongoing basis as part of the approved centre's provision of care. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. Adequate arrangements were in place for residents to access required general health services. Information was provided in relation to national screening programmes and residents were encouraged to partake in national screening. This included Breast Check, cervical screening, retina check (diabetics only), and bowel screening.

In terms of smoking cessation, the National HSE policy was utilised, and the campus has been "smoke free" since January 2018. Nicotine Replacement Therapy (NRT) was available to residents to support smoking cessation. No residents requested assistance in smoking cessation at the time of inspection.

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

## Regulation 20: Provision of Information to Residents

**NON-COMPLIANT**

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

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the provision of information to residents. The policy was last reviewed in January 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for managing the provision of information to residents' representatives, family, and next of kin, as appropriate.

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

**Monitoring:** The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

**Evidence of Implementation:** The information booklet for the approved centre contained the following: housekeeping arrangements, including arrangements for personal property and mealtimes; complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies; and residents' rights. Residents had access to interpretation and translation services as required.

Residents were not provided with written and verbal information on diagnoses. No written medication information sheets were available.

**The approved centre was non-compliant with this regulation because residents or families were not provided with relevant information regarding diagnosis or the effects of medications, 20 (1) (c).**

## Regulation 21: Privacy

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to resident privacy, which was last reviewed in October 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

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

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

**Evidence of Implementation:** Staff were respectful of residents. Staff were appropriately dressed. Resident issues were only discussed in private and out of the hearing range of other residents. All residents were observed to be dressed in clean and appropriate personal clothing. Shared rooms had adequate bed screening between beds to ensure and safeguard resident's privacy and dignity. The approved centre was located on the first floor and was not overlooked by surrounding properties.

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

## Regulation 22: Premises

**NON-COMPLIANT**

**Quality Rating** Requires Improvement

**Risk Rating** HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to its premises, which was last reviewed in August 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 could articulate the processes relating to the maintenance of the premises, as set out in the policy.

**Monitoring:** The approved centre had not 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:** The approved centre was adequately lit, heated, and ventilated. Heating was centrally controlled and it could not be controlled in the resident's own room. Appropriate signage and sensory aids such as pictorial, written, braille, and photographic prompts were provided to support resident orientation needs. Resident bedrooms were appropriately sized to address the resident needs. There was a sufficient number of toilets and showers for residents in the approved centre. The approved centre provided assisted devices and equipment such as mobile hoists and ceiling hoists to address resident needs.

Hazards were minimised. Ligature point risks were not minimised, and there were no active steps being taken at the inspection time to minimise risks. Due to the resident group profile and conditions, they were considered to be of low risk in relation to the ligatures.

The communal rooms and areas provided such as the dining room, sitting room, and outdoor spaces were all too small to accommodate the number and mix of residents using them. This environmental design did not support resident' independence and comfort, and overall residents' needs. Residents did not have

adequate space to move about in. During the inspection, it was observed that the medication trolley was unsuitably placed in the limited sitting room space.

Residents did not have sufficient access to outdoor spaces including external gardens; access was not possible unless staff were specifically available to accompany residents outside. Most residents had mobility limitations and needed assistance to access the garden area located on the ground floor, which was one floor underneath the approved centre and was only accessible through lifts and stairs.

There was also a small, inadequately designed outdoor space on the first floor. It was located opposite the resident's sitting room but this outdoor space was not big enough to be used by 24 residents.

There was no programme of routine, general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment, developed and implemented. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Long delays were apparent in relation to the addressing of maintenance issues which resulted in maintenance issues becoming urgent.

The approved centre was clean, hygienic, and free from offensive odours. It was kept in a good state of repair inside and outside. Remote or isolated areas of the approved centre were monitored.

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

a) **It did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre. Communal areas including the sitting room and dining room was too small to accommodate the number of residents. External gardens not adequately sized to meet residents' needs. 22 (2).**
b) **The approved centre was located on the first floor and residents did not have direct access to outdoor space, therefore the building was not developed and maintained with due regard to the specific needs of the residents, 22 (3).**
c) **A medication trolley was placed in the sitting room, which was a barrier to residents space and environmental appeal, 22 (3).**
d) **There was no programme of routine maintenance, developed and implemented, 22 (1) (c).**

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

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in January 2016. The policy was under review at the time of inspection and not yet available to staff. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for self-administration of medication.
- The process for medication reconciliation.

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

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

**Evidence of Implementation:** All entries in the MPARs were legible. All entries in the MPARs were written in black indelible ink. The MPARs had a maximum capacity of eight weeks before a re-write was required. This was documented in the clinical file. The prescription was not altered where a change was required. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs (except those for self-administration), were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber, and any advice provided by the resident's pharmacist regarding the appropriate use of the product.

The expiration date of the medication was checked prior to administration. Expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. Schedule 2 controlled drugs were checked by two staff members against the delivery form and details were entered in the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book. Following administration, the details were entered in the controlled drug book and signed by both staff members.
Administration of crushed medication required written instruction from the prescriber on the MPAR. The medical practitioner provided a documented reason why the medication was to be crushed. The

pharmacist was consulted about the type of preparation to be used. The medical practitioner documented in the MPAR that the medication was to be crushed.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. Food and drink was not stored in areas used for the storage of medication. Medication was kept in a locked trolley in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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

## Regulation 24: Health and Safety

**COMPLIANT**

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

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

### INSPECTION FINDINGS

**Processes:** There were a number of policies in relation to Regulation 24, Health and Safety. The approved centre had a written policy in relation to health and safety. It was the generic North Dublin Mental Health Services policy and it was last reviewed in January 2016. The policies combined included requirements of *the Judgement Support Framework,* with the following exceptions:

- The allocation of specific roles to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- A fire management plan.

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

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

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

**The approved centre was compliant with this regulation.**

## Regulation 26: Staffing

**NON-COMPLIANT**

**Quality Rating** Requires Improvement
**Risk Rating** HIGH

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in October 2016. The policy 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 policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

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

**Evidence of Implementation:** Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment. The approved centre had vacancies for two occupational therapy posts and principal social work post. The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times. 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.

All staff training was documented. Not all health care staff were trained in the following:

- Fire safety
- Basic Life Support
- The Professional Management of Violence and Aggression, (PMAV)

- The Mental Health Act 2001
- Children First

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
|---|---|---|---|
| | ADON | 1.0 | 1.0 (On call) |
| | CNM3 | 1.0 | 1.0 (On call) |
| | CNM2 | 1 | 0 |
| O' Casey Rooms | CNM1 Activity Area | 1 | 0 |
| | RPN | 4 | 0 |
| | HCA | 2 | 2 |
| | | | 2 |
| | Internship Student (X2) | 1.0 ( Jan- Sept) | |

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

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

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

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

## Regulation 27: Maintenance of Records

**NON-COMPLIANT**

**Quality Rating** Requires Improvement

**Risk Rating** MODERATE

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in January 2016. The policy did not address the process for making a retrospective entry in the residents' records.

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

**Monitoring:** Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

**Evidence of Implementation:** Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were written legibly in black indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

Not all residents' records were secure, up to date, and in good order. In one case, the clinical file inspected evidenced loose pages in relation to a discharge summary and transfer information. Some dividers were crumpled and removed.

Not all resident records were physically stored together. In one case, the resident's files were spread between folders which were not physically stored together. The Mental Health Act Administrator kept the resident's Mental Health Tribunal documentation. Additional information was kept in a separate folder. Copies of all of the relevant documentation were not in the current file or on the unit.

Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) **Not all records were easily retrievable 27 (1).**
b) **Not all records were kept in good order 27 (1).**

## Regulation 28: Register of Residents

**NON-COMPLIANT**

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

(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 hard copy 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, data regarding resident admission and discharge dates was inaccurate on the register.

**The approved centre was non-compliant with this regulation because data regarding admission and discharge dates was inaccurate on the register, 28 (1).**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in January 2017. It 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 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 required by the regulations were all reviewed within the required three-year time frame. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

Where generic policies were used, the approved centre had a written statement adopting the generic policy, which was reviewed at least every three years. Any generic policies used were appropriate to the approved centre and the resident group profile.

The format of policies and procedures was not fully standardised. Policies did not include the individual names of approvers and reviewers.

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

## Regulation 30: Mental Health Tribunals

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in January 2016. The policy and procedures addressed requirements of the *Judgement Support Framework*, with the exception of the provision of information to the patient regarding the Mental Health Tribunals.

**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 for facilitating Mental Health Tribunals, as set out in the policy.

**Monitoring:** Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

**Evidence of Implementation:** The approved centre provided private facilities to support the Mental Health Tribunal process. The approved centre provided adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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

## Regulation 31: Complaints Procedures

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy in relation to the management of complaints. The policy was last reviewed in January 2016. The policy did not address the confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.

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

**Monitoring:** No complaints were received in the preceding year, and auditing was therefore not applicable.

**Evidence of Implementation:** The nominated person responsible for dealing with complaints was based within the unit and was the Clinical Nurse Manager 2. The complaints officer was offsite but was clearly identified with contact details. The approved centre's management of complaints was well publicised and accessible to residents and their representatives.

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

## Regulation 32: Risk Management Procedures

**NON-COMPLIANT**

**Quality Rating** Requires Improvement
**Risk Rating** HIGH

(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 October 2016. The policy addressed requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the following:

- The responsibilities of the registered proprietor.
- A defined quality and safety oversight and review structure as part of the governance process for managing risk.
- Capacity risks relating to the number of residents in the approved centre.

**Training and Education:** Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Not 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 person with responsibility for risk was identified and known by all staff. Clinical, health and safety, and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register.

Individual risk assessments were completed prior to and during mechanical restraint, at admission to identify individual risk factors, at resident transfer, at resident discharge, and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

There was evidence that the conditions attached to the Mental Health Commission registration were recorded on the corporate risk register. The risk management procedures actively reduced identified risks to the lowest practicable level of risk in relation to falls prevention. There was no action plan identified to reduce ligature points. A group approach to managing risks was adopted, rather than being based on individual risk assessment.

There was no emergency/evacuation plan in place which specified the required response by approved centre staff to possible emergencies. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission on an anonymised basis.

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

a) **The risk management policy did not cover the identification and assessment of capacity risks relating to the number of residents in the approved centre 2 (a).**
b) **The risk management policy did not cover the precautions in place to control the risks identified, 2 (b).**
c) **The risk management policy did not cover arrangements for responding to emergencies, 2 (e).**

## Regulation 33: Insurance

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two conditions to registration attached. The certificate was displayed prominently.

**The approved centre was compliant with this regulation.**

# 9.0 Inspection Findings – Rules

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

## Section 69: The Use of Mechanical Restraint

**COMPLIANT**

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

The clinical files of two residents who had been mechanically restrained was inspected. Mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the residents or the duty consultant psychiatrist acting on their behalf.

The clinical files contained a contemporaneous record that specified the following:

- That less restrictive alternatives were implemented without success.
- That there was an enduring risk of harm to self or to others
- The type of mechanical restraint.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

**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 of  Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

# 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.

## Admission, Transfer and Discharge

**NON-COMPLIANT**

**Risk Rating** MODERATE

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

### INSPECTION FINDINGS

**Processes:** The approved centre had separate policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in November 2016. The transfer policy was last reviewed in January 2016, and the discharge policy was last reviewed in January 2014. The policies combined included all of the policy-related criteria of this code of practice.

**Training and Education:** There was no documentary evidence to indicate 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 and transfer policy. There had been no discharges since the last inspection.

**Evidence of Implementation:**

**Admission:** The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident received an admission assessment which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

**Discharge:** As no discharges had taken place since the last inspection, this part of the Code of Practice was not inspected against.

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

a) **Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.**
b) **The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.**

## Appendix 1: Corrective and Preventative Action Plan

## Regulation 15: Individual Care Plan

*Report reference: Page 29*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 1. The ICP process and documentation did not confirm that the process was undertaken as far as practicable in consultation with each resident. It was unclear whether the resident or key-worker attended the ICP review process. | New | Corrective Action(s):<br>Ensure that the resident and keyworker, as far as practicable, attend the ICP process.<br>Post-Holder(s) responsible:<br>Heads of Discipline | Completion of the ICP Checklist<br>Monthly audit of the ICP process | Achievable & Realistic | On-going with effect from December 16th 2018. |
| | | Preventative Action(s):<br>Provide ICP training for all clinical staff.<br>Post-Holder(s) responsible:<br>Heads of Discipline | Training Records | Achievable & Realistic | 1st Quarter 2019 |
| 2. In a number of cases the review documentation was incomplete regarding whether the resident was offered a copy, or if not, why not. | New | Corrective Action(s):<br>Review all ICP Checklists to identify incomplete documentation<br>Post-Holder(s) responsible:<br>Clinical Lead from MDT | Completion of the ICP Checklist<br>Monthly audit of the ICP process | Achievable & Realistic | 1st Quarter 2019 |
| | | Preventative Action(s):<br>Provide ICP training for all clinical staff<br>Post-Holder(s) responsible:<br>Heads of Discipline | Training Records | Achievable & Realistic | 1st Quarter 2019 |

## Regulation 18: Transfer of Residents

*Report reference: Page 31*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 3. All relevant information about the resident was not provided to the receiving approved centre, 18 (1). | New | Corrective Action(s):<br>Copy of records relevant to transfer to be retained in clinical file<br>Post-Holder(s) responsible:<br>CNMII O'Casey Rooms | Complete the Transfer Checklist<br>Audit the transfer checklist after each transfer of resident | Achievable & Realistic | Following the transfer of a resident |
| | | Preventative Action(s):<br>Transfer Checklist training to be facilitated by CNMIII<br>Post-Holder(s) responsible:<br>Heads of Discipline | Training Records | Achievable & Realistic | 1st Quarter 2019 |

## Regulation 20: Provision of Information to Residents

*Report reference: Page 33*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 4. Residents or families were not provided with relevant information regarding diagnosis or the effects of medications, 20(1)(c). | New | Corrective Action(s):<br>All residents or families will be provided with relevant information regarding diagnosis or the effects of medications<br>Post-Holder(s) responsible:<br>Consultant Psychiatrist | Quarterly audit of Regulation 20 – Provision of information to residents | Achievable/Realistic | Quarterly |
| | | Preventative Action(s):<br>All residents or families will be provided with relevant information regarding diagnosis or the effects of medications<br>Post-Holder(s) responsible:<br>Consultant Psychiatrist | Quarterly audit of Regulation 20 – Provision of information to residents | Achievable/Realistic | Quarterly |

## Regulation 22: Premises

*Report reference: Page 35 & 36*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 5. The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre. Communal areas including the sitting room and dining room were too small to accommodate the number of residents. External gardens not adequately sized to meet residents' needs. 22 (2). | *New* | Corrective Action(s):<br>Reconvene the Working Group to redesign the current layout of O'Casey Rooms<br>Post-Holder(s) responsible:<br>Clinical Director | Agreed actions from working group meetings. | Achievable & Realistic | 2nd Quarter 2019 |
| | | Preventative Action(s): Reduce the bed numbers to facilitate the redesign of the unit<br>Post-Holder(s) responsible: O'Casey Rooms Working Group | Decrease in bed numbers | Achievable & Realistic | 2nd Quarter 2019 |
| 6. The approved centre was located on the first floor and residents did not have direct access to outdoor space, therefore the building was not developed and maintained with due regard to the specific needs of the residents, 22 (3). | *Reoccurring* | Corrective Action(s): Business case submitted to Head of Service Mental Health for alternate accommodation to be sourced by HSE Estates.<br>Post-Holder(s) responsible: | Alternative accommodation sourced | Finance dependent | 2022 |
| | | Preventative Action(s):Implement "A Breath of Fresh Air" Programme<br>Post-Holder(s) responsible: CNMI in conjunction with CNMIIs of O'Casey and Occupational Therapists. | Maintain record of participants | Achievable & Realistic | On-going and continuous |
| | *New* | Corrective Action(s): Identify a location to dispense medication | Location identified | Achievable & Realistic | Q2 2019 |

| | | | | | |
|---|---|---|---|---|---|
| *7.* A medication trolley was placed in the sitting room, which was a barrier to residents space and environmental appeal, 22 (3). | | which will not impact on the environmental appeal<br>Post-Holder(s) responsible: ADoN O'Casey Rooms | following redesign of unit | | |
| | | Preventative Action(s): Store the medication trolley following administration of medications<br>Post-Holder(s) responsible: ADoN & CNMIIs O'Casey Rooms | Medication Management Audit | Achievable & Realistic | Immediate |
| 8. There was no programme of routine maintenance, developed and implemented, 22 (1) (c). | *Reoccurring* | Corrective Action(s): Routine programme of maintenance to be developed and submitted to SVHF Technical Services<br>Post-Holder(s) responsible: CNMIIs & ADoN O'Casey Rooms<br>Implement maintenance programme<br>Post Holder Responsible : CEO SVHF | Routine Maintenance programme to be developed<br><br>Implementation of programme | Achievable and Realistic<br><br>Dependent on SVHF Management | 1st Quarter 2019<br><br>To be confirmed |
| | | Preventative Action(s):<br>Escalate outstanding issues to the Management Team monthly outstanding<br>Post-Holder(s) responsible: CNMII O'Casey Rooms | Maintenance updates to be provided every month to the MT | Achievable & Realistic | 1st Quarter 2019 |

## Regulation 26: Staffing

*Report reference: Page 40 & 41*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 9. Not all staff had up-to-date mandatory training in Basic Life Support, Fire safety, PMAV, 26(4)<br>10. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5). | *Reoccurring* | Corrective Action(s):<br>All relevant staff to be identified and assigned training dates as soon as practicable. Training needs analysis to be updated.<br>Post-Holder(s) responsible: Heads of Discipline | Training needs analysis updated<br>Review monthly training records | Release of staff for training a challenge due to service need | Ongoing. |
| | | Preventative Action(s): Identify training needs for 2019 via the training needs analysis<br>Post-Holder(s) responsible: CNMIIs, ADoN O'Casey Room. CNMIII will audit same. | Monthly audit. | Achievable & Realistic | Ongoing. |

## Regulation 27: Maintenance of Records

*Report reference: Page 42 & 43*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 11. Not all records were easily retrievable 27(1). | *New* | Corrective Action(s):<br>Prepare a Business Case for submission to the HOS Mental Health for a ward clerk for the O'Casey Rooms<br>Post-Holder(s) responsible:<br>Service Manager | Business Case completed and submitted | Achievable and realistic | December 2018 |
| | | Preventative Action(s):<br>Establish a Record Management Working Group for the O'Casey Rooms<br>Post-Holder(s) responsible:<br>Deputy Service Manager | Working Group established | Achievable and realistic | January 2019 |
| 12. Not all records were kept in good order 27(1). | *Reoccurring* | Corrective Action(s):<br>Prepare a Business Case for submission to the HOS Mental Health for a ward clerk for the O'Casey Rooms<br>Post-Holder(s) responsible:<br>Service Manager | Business Case submitted and completed | Achievable and realistic | December 2018 |
| | | Preventative Action(s):<br>Establish a Record Management Working Group for the O'Casey Rooms<br>Post-Holder(s) responsible:<br>Deputy Service Manager | Working Group established | Achievable and realistic | December 2018 |

## Regulation 28: Register of Residents

*Report reference: Page 44*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 13. Data regarding admission and discharge dates was inaccurate on the register, 28 (1). | New | Corrective Action(s):<br>Review the information for accuracy in terms of admission, transfer and discharge<br>Complete a data cleanse of the register<br>Post-Holder(s) responsible: CNMII & CNMIII O'Casey Rooms | Audit after each admission, transfer and discharge | Achievable & Realistic | December 2018 |
| | | Preventative Action(s):<br>Post-Holder(s) responsible:<br>Workshop to be held for staff regarding making accurate entries in the register. | Workshop completed | Achievable & Realistic | December 2018 |

## Regulation 32: Risk Management Procedures

*Report reference: Page 48 & 49*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 14. The risk management policy did not cover the identification and assessment of capacity risks relating to the number of residents in the approved centre 32(2)(a). | *Reoccurring* | Corrective Action(s):<br>Amend the risk management policy to cover the identification and assessment of capacity risks relating to the number of residents in the approved centre 32(2) (a).<br>Post-Holder(s) responsible:<br>Chairperson of Policy Group | Policy amended | Achievable and realistic | December 2018 |
| | | Preventative Action(s):<br>Amend the risk management policy to cover the identification and assessment of capacity risks relating to the number of residents in the approved centre 32(2) (a).<br>Post-Holder(s) responsible<br>Chairperson of Policy Group | Policy amended | Achievable and realistic | December 2018 |
| 15. The risk management policy did not cover the precautions in place to control the risks identified, 32(2)(b). | *New* | Corrective Action(s):<br>Amend the risk management policy to cover the precautions in place to control the risks identified, 32(2) (b).<br>Post-Holder(s) responsible:<br>Chairperson of Policy Group | Policy amended | Achievable and realistic | December 2018 |

| | | | | | |
|---|---|---|---|---|---|
| | | Preventative Action(s):<br>Amend the risk management policy to cover the precautions in place to control the risks identified, 32(2)(b).<br>Post-Holder(s) responsible:<br>Chairperson of Policy Group | Policy amended | Achievable and realistic | December 2018 |
| 16. The risk management policy did not cover arrangements for responding to emergencies, 32(2)(e). | *New* | Corrective Action(s):<br>Amend the risk management policy to cover arrangements for responding to emergencies, 32(2)(e).<br>Post-Holder(s) responsible:<br>Chairperson of Policy Group | Policy amended | Achievable and realistic | December 2018 |
| | | Preventative Action(s):<br>Amend the risk management policy to cover arrangements for responding to emergencies, 32(2)(e).<br>Post-Holder(s) responsible:<br>Chairperson of Policy Group | Policy amended | Achievable and realistic | December 2018 |

## Code of Practice: Admission, Transfer and Discharge

*Report reference: Page 56*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 17. Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1. | New | Corrective Action(s): All staff to read the policy & sign accordingly.<br>Post-Holder(s) responsible: Heads of Discipline | Monthly Audit | Achievable & Realistic | December 2018 |
| | | Preventative Action(s): All staff are to be given protected time to read & understand policies and to document same in policy log.<br>Post-Holder(s) responsible: Heads of Discipline | Policy logs are maintained on O'Casey and same to be monitored & audited to ensure staff have read policies. | Achievable & Realistic | Ongoing. |