St. Anne’s Unit, Sacred Heart Hospital

ID Number: AC0072

2018 Approved Centre Inspection Report (Mental Health Act 2001)

St Anne’s Unit
Sacred Heart Hospital
Pontoon Road
Castlebar
Co. Mayo

Approved Centre Type: Psychiatry of Later Life

Most Recent Registration Date: 1 October 2017

Conditions Attached
None

Registered Proprietor: HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, CHO2 – Mental Health Services

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Dr Ann Marie Murray MCRN363031
Dr Enda Dooley MCRN004155

Inspection Date:
20 – 23 February 2018

Inspection Type:
Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Previous Inspection Date:
30 May – 2 June 2017

Date of Publication:
11 October 2018

2018 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable

9
3
19
4
3
1
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
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1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

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

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required. Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

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

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken. In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.
2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services  
Dr Susan Finnerty

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

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

In Brief

St Anne’s Unit was a 12-bed approved centre in Castlebar, Co. Mayo, with three single bedrooms and four shared bedrooms. St. Anne’s Unit was a locked, interim assessment ward for people over the age of 65 years. The resident profile was mainly people living with dementia. Elderly residents with acute mental illness were also admitted to the approved centre. Compliance with regulations and codes of practice had decreased from 81% in 2017 to 63% in 2018. The centre was risk rated as critical in medication management. There were no areas rated as excellent in this inspection.

Safety in the approved centre

A minimum of two resident identifiers were used. There was no documentary evidence that food safety audits had been undertaken. Catering areas were clean and hygienic, in line with food-safety requirements.

Not all health care professionals had up-to-date, mandatory training in fire safety, the management of aggression and violence, and the Mental Health Act 2001 and Children First. They had up-to-date training in Basic Life Support.

There were prescription and administration errors in some medication prescription and administrative records. Medication was stored safely.

Structural risks, notably multiple ligature points, had not been removed or effectively mitigated. The risk register did not highlight the issue of multiple ligature points and the ligature audit had not been updated to reflect the change in resident profile from mainly dementia to including residents with major mental illnesses.
Appropriate care and treatment of residents

Each resident had an individual care plan (ICP). There was no evidence of resident involvement in the ICP review process and no documented evidence of an assessment of the resident’s functional capacity before the decision was made not to engage the resident in the process. There was no clear evidence that the ICP was updated based on a review of progress aimed at addressing resident goals. There was no evidence that residents were offered a copy of their ICP and a reason for this was not recorded.

The range of therapeutic services and programmes available in the approved centre was appropriate to the assessed needs of residents. Input was available from the team psychologist and the occupational therapist, as required, and detailed in the ICP. The therapeutic services and programmes provided were evidence-based.

Where required, the approved centre used the St. Andrew’s Nutritional Screening Instrument to identify residents’ nutritional needs and residents had access to dietetics or speech and language therapy assessments relating to potential nutritional requirements. Residents’ general health needs were monitored and assessed at least every six months, and there were arrangements in place for residents to access general health services and for their referral to other health services as required.

Respect for residents’ privacy, dignity and autonomy

The approved centre was a locked unit to ensure the safety and welfare of residents whose level of cognitive functioning was severely impaired due to advanced dementia. Access to the unit was by a locked door and a keypad. No clear rationale for the double locking system was provided to the inspectorate team. The residents did not have free access to the activity room in the approved centre as it was locked four days a week, on days when the activity nurse was not present. No clear rationale for locking the door was provided and there had been no review of this practice.

Residents were not supported to manage their own property. It was assumed that residents were unable to do so and all were requested to hand over any monies at admission to nursing staff for safe-keeping. There was no evidence that the residents had been assessed in terms of their capacity to manage their own property. There was a large, open-plan visiting room, which was furnished in a manner that facilitated private visits and accommodated visiting children. Residents wore their own clothes.

Privacy was respected apart from the lack of appropriate screening of the observation panel on the door of one single bedroom.

One resident had received medication covertly without the completion of a capacity assessment.

Residents’ records were stored in an open trolley in the nurse’s station, which was observed to be unlocked and unsupervised at times over the course of the inspection.
Responsiveness to residents’ needs

Menus had been approved by the dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents were offered a choice of wholesome and nutritious food. Food, including modified consistency diets, was presented in an appealing manner. The approved centre provided a range of recreational activities appropriate to the resident group profile, during the week and at weekends. Residents were provided with an information booklet at admission.

Not all residents had access to written and verbal information regarding their diagnosis. Only written information relating to a diagnosis of dementia was available, but it was dated 2012. Written information on diagnosis was not always provided to residents who did not have a diagnosis of dementia.

The interior of the approved centre was well maintained, but the exterior gardens were not. There was no programme of routine decorative maintenance. There was an appropriate maintenance reporting process, but there had been unexplained delays in relation to repairing a broken shower and toilet in the approved centre. A cleaning schedule was implemented within the approved centre. However, it was not hygienic throughout and current national infection control guidelines were not being followed.

Governance of the approved centre

The approved centre was part of the HSE’s Community Healthcare Organisation (CHO) area 2, which comprised Galway/Roscommon and Mayo services. The area management team of Mayo Mental Health Services were responsible for the overall management and governance of the approved centre. The area management team met monthly and minutes were available to the inspectorate team. A Judgement Support Framework Group meeting had been set up to assist in improving quality systems within the approved centre. There were two Psychiatry of Later Life teams; north and south. Both had responsibility for the care and treatment of residents in St Anne’s Unit.

There were no written admission criteria for the approved centre, and no clear strategic plan for the future of the resident profile. Operating policies and procedures were developed with input from clinical and managerial staff in consultation with all relevant stakeholders.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre has introduced an activities nurse to assist in providing activity programmes to meet the residents’ needs.

2. The Community Healthcare Organisation had appointed a compliance officer who will contribute to the development of best practice guidelines for Mental Health Services.

3. The approved centre has introduced a falls policy for the prevention and management of falls.

4. The introduction of a suggestion box in the approved centre for residents and their families to encourage feedback with regard to new ideas for the unit.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located in the grounds of the Sacred Heart Hospital on Pontoon Road in Castlebar, Co. Mayo. The single-storey building dated from the 1970s. There were 12 beds in the approved centre, comprising three single bedrooms and four shared bedrooms. St. Anne’s Unit was a locked, interim assessment ward for people over the age of 65 years. The resident profile was mainly people living with dementia. Residents with acute mental health illness were also admitted to the approved centre.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>12</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>6</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>4</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was part of the HSE’s Community Healthcare Organisation (CHO) area 2, which comprised Galway/Roscommon and Mayo services. There was an organisational chart with governance structures and processes in place. The area management team of Mayo Mental Health Services were responsible for the overall management and governance of the approved centre. The area management team met monthly and minutes were available to the inspectorate team. A Judgement Support Framework Group meeting had been set up to assist in improving quality systems within the approved centre. There were two Psychiatry of Later Life teams; north and south. Both had responsibility for the care and treatment of residents in St Anne’s Unit.
There were no written admission criteria for the approved centre, and no clear strategic plan for the future of the resident profile. Operating policies and procedures were developed with input from clinical and managerial staff in consultation with all relevant stakeholders.

4.5 Use of restrictive practices

The approved centre was a locked unit. This was to ensure the safety and welfare of residents whose level of cognitive functioning was severely impaired due to advanced dementia. Access to the unit was by a locked door and a keypad. No clear rationale for the double locking system was provided to the inspectorate team.

The residents did not have free access to the activity room in the approved centre as it was locked four days a week, on days when the activity nurse was not present. No clear rationale for locking the door was provided. There had been no review of this practice.
5.0 Compliance

5.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing and Administration of Medicines</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Low</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Low</td>
<td>X</td>
</tr>
</tbody>
</table>

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

5.2 Areas of compliance rated “excellent” on this inspection

No areas of compliance were rated excellent on this inspection.
### 5.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As no resident had been mechanically restrained since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>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.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

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

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

The inspection team met with one resident who was complimentary of the care and treatment provided by St. Anne’s Unit. The resident also spoke highly of the quality of the food in the approved centre. There were no service user experience questionnaires returned to the inspectorate team.
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:

- Consultant Psychiatrist
- Area Director of Nursing
- Senior Clinical Psychologist
- Acting Occupational Therapy Manager
- Principal Social Worker
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Business Manager
- Activities Nurse
- Nurse Practice Development Coordinator
- Compliance Manager
- Quality and Risk Advisor
- Nursing student

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Discussion was generated with regard to the inspection team’s feedback on Regulation 15, Individual Care Plans and with regard to restrictive practices and the double locking system on external doors within the approved centre.
8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in October 2016. The policy addressed 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.

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

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs, were used. The preferred identifiers were photographs on Medication Prescription and Administration Records and addressograph labels on clinical files. The identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used before the administration of medication, the undertaking medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre had a system for alerting staff to the presence of residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in August 2016. 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 interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans was undertaken by the catering manager in consultation with the dietitian to ensure that residents received wholesome and nutritious food in accordance with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Menus had been approved by the dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Hot meals were provided daily. Residents had a choice of three options for their main courses. Food, including modified consistency diets, was presented in an appealing manner. Residents were offered hot drinks regularly, and fresh water was available from the nurses’ office on request.

Where required, the approved centre used the St. Andrew’s Nutritional Screening Instrument to identify residents’ nutritional needs. Staff indicated that, where required, residents had access to dietics or speech and language therapy assessments relating to potential nutritional requirements. Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans.

There was no process in place to ensure that residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindications with medication.

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 pillars.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written food safety policy, which was last reviewed in October 2016. It addressed requirements of the Judgement Support Framework, with the exception of the process for adhering to the relevant food safety legislative requirements.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. Training records indicated that not all staff handling food had up-to-date training in food safety/hygiene commensurate with their role. Food safety training was documented, and evidence of certification was available, where applicable.

Monitoring: There was no documentary evidence that food safety audits had been undertaken. Food temperatures were recorded in line with food safety recommendations, and a temperature log sheet was maintained and monitored in the kitchen area. Documented analysis had not been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: The approved centre had appropriate hand-washing areas for catering staff as well as suitable and sufficient catering equipment. There were appropriate facilities for the refrigeration, storage, and preparation, cooking, and serving of food. Catering areas were clean and hygienic in line with food-safety requirements. Residents were provided with a supply of suitable crockery and cutlery.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in November 2017. It addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: As all admissions were planned, the approved centre did not maintain an emergency supply of resident clothing. No residents had been recorded as wearing nightclothes during the day since the last inspection.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, which was clean and appropriate to their needs. An emergency supply of resident clothing was not maintained, but there was an emergency fund for purchasing clothes if they were required. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

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 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in February 2018. It 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, which, at the time of inspection, had just been introduced. Relevant staff interviewed were unable to articulate the processes relating to residents’ property and possessions, as set out in the policy.

Monitoring: Residents’ personal property logs were monitored. Documented analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre, the extent of which was agreed at admission. Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of residents’ money, valuables, personal property, and possessions.

The files of three residents were inspected in relation to residents’ personal property and possessions. These files indicated that a property checklist was completed for each resident at admission and was updated on an ongoing basis in line with the approved centre’s policy. The checklists were kept separately to the residents’ individual care plans and were available to the respective residents.
Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained. However, in two of the clinical files examined, the records had not been countersigned by the resident or their representative. Residents were not supported to manage their own property. It was assumed that residents were unable to do so and were requested to entrust any monies at admission to nursing staff for safe-keeping. In two of the clinical files inspected, there was no evidence that the residents had been assessed in terms of their capacity to manage their own property. In addition, neither resident’s individual care plan contained evidence that an assessment had been completed in relation to any risk associated with each resident retaining control over their personal property and possessions.

The approved centre was non-compliant with this regulation because residents were not supported to manage their own property and were not assessed in relation to any risks associated with retaining control over their personal property and possessions, 8(5).
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The process for risk-assessing residents for recreational activities, apart from outdoor activities.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided a range of recreational activities appropriate to the resident group profile, including chair exercises, watching DVDs, listening to music, and washing dishes and clothes for reminiscence purposes under supervision. Recreational activities were facilitated during the week and at weekends.

A schedule of recreational activities was posted up on the activities board. Staff noted that there were plans to display dementia-friendly information on the board, which would be more appropriate to residents’ needs. This information did not indicate the frequency of recreational activities available in the approved centre.

Recreational activity programmes were developed, implemented, and maintained with resident input. Where deemed appropriate, individual risk assessments were completed for residents in relation to the selection of activities. Documentation of resident attendance at activities was maintained in the form of group records. Residents’ decisions on whether or not to participate in activities were respected and documented. Adequate communal areas suitable for recreational activities were provided.
Due to recent adverse weather conditions, opportunities were not always provided for residents to engage in outdoor exercise and physical activity in the external courtyard. Residents had not had access to any social outings since November 2017 due to the adverse weather events.

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 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the facilitation of religious practice by residents, which was last reviewed in November 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 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 had not been reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. Facilities were provided in support of residents’ religious practices. Mass was available within the approved centre on a weekly basis, and access to multi-faith chaplains was provided as required. Residents could attend religious services locally subject to a risk assessment and the availability of suitable staff or family members to accompany them.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes. At the time of inspection, no resident had specific religious requirements relating to the provision of services, care, and treatment.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to visits, which was last reviewed in May 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 interviewed were able to articulate the processes relating to visits, as set out in the policy.

**Monitoring:** At the time of inspection, there were no restrictions on residents’ rights to receive visitors. Documented analysis had not been completed to identify opportunities for improving visiting processes.

**Evidence of Implementation:** Visiting times, which were appropriate and reasonable, were publicly displayed at the main entrance and within the approved centre. Appropriate steps were taken to ensure the safety of residents and visitors during visits. There was a large, open-plan visiting room, which was furnished in a manner that facilitated private visits and accommodated visiting children. Children visiting were accompanied at all times to ensure their safety, and this was communicated via public notices.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication, which was last reviewed in May 2017. It addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ communication needs and restrictions on communication were monitored on an ongoing basis. Analysis had been undertaken in relation to the introduction of easy-to-read leaflets, but it had not been documented.

Evidence of Implementation: Residents had access to a range of communications, including mail, e-mail, internet and telephone. Individual risk assessments were completed for residents in relation to any risks associated with their external communication and documented in their individual care plan. At the time of inspection, no residents were subject to communication restrictions.

Since the last inspection, neither the clinical director nor a designated senior member of staff had examined incoming and outgoing communication on the basis that it may result in harm to the resident or others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in January 2018. The policy and procedures 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: 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 searching processes, as set out in the policy.

As the approved centre did not conduct searches, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in February 2018. The policy and protocols 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 end of life care, as set out in the policy.

One resident had died in the general hospital while on transfer. As there had been no deaths in the approved centre since the last inspection and no residents had required end of life care, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

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

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

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

INSPECTION FINDINGS

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

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: The ICPs of five residents in the approved centre were inspected. Each ICP was stored within an identified tab in the respective clinical file. The ICP template contained allocated sections for goals, treatment, care, resources, and reviews. The ICP was identifiable and uninterrupted, and it was not amalgamated with progress notes.

The ICPs were not discussed, agreed where practicable, or developed with the involvement of residents. Residents did not sign their ICP or receive a copy of it. No documentation was available in relation to why residents were not offered copies of their ICPs or if they had declined or refused a copy. None of the ICPs reviewed contained an individual risk management plan. Although separate individual risk assessments were undertaken and documented, they were not integrated into the ICP. In addition, there was no reference in the ICP or the ICP review to risk assessment or risk management.

Residents were assessed at admission, and an initial ICP was put in place immediately. The ICP was completed by the multi-disciplinary team (MDT) within seven days of admission, following a comprehensive assessment. Each ICP identified appropriate goals for the resident and the care and treatment required to meet those goals, including the frequency and responsibilities for implementing the care and treatment. The ICPs specified the resources required to provide the care and treatment.
identified, and they identified a key worker with responsibility to ensure continuity in the implementation of the ICP. Although the ICPs identified residents’ assessed needs, these were not always appropriate.

The ICPs were reviewed by the MDT, but there was no evidence of resident involvement in the review process, insofar as was practical. There was no documented evidence of an assessment of functional capacity in advance of deciding not to engage the resident in the ICP review process. As documented, the ICP update was not based on a review of residents’ changing needs, condition, circumstances, and goals.

As children were not admitted to the approved centre, educational requirements in relation to the ICP did not apply.

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

a) There was no evidence of resident involvement in the ICP review process and no documented evidence of an assessment of the resident’s functional capacity before the decision was made not to engage the resident in the process.

b) There was no clear evidence that the ICP was updated based on a review of progress aimed at addressing resident goals.

c) There was no evidence that residents were offered a copy of their ICP and a reason for this was not recorded.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in May 2017. It addressed 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 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 not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The range of therapeutic services and programmes available in the approved centre was appropriate to the assessed needs of residents, as documented in their individual care plans (ICPs). Input was available from the team psychologist and the occupational therapist, as required, and detailed in the ICP. The therapeutic services and programmes provided were evidence-based, and they were directed towards maintaining optimal levels of physical and psychosocial functioning. They included relaxation, exercise, sensory stimulation, music therapy, personal care, aromatherapy/light massage, and reminiscence/life stories therapy.

A list of therapeutic services and programmes was available in the approved centre. Adequate and appropriate resources were in place to facilitate the provision of therapeutic services and programmes, including a dedicated activity room. The activities nurse maintained a list of residents’ participation and engagement in group and individual programmes.

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 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in June 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 interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A record of admissions, transfers, and discharges was available to the inspectorate team. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not 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 to hospital in an emergency circumstance was reviewed. The communication records with the receiving facility were clearly documented and included the reason for the transfer; the resident’s care and treatment plan, including needs and risk; and whether the resident required accompaniment on transfer. A pre-transfer assessment of the resident was completed, including an individual risk assessment relating to the transfer and the resident’s needs. Full and complete written information relating to the resident was provided to the receiving facility.

Relevant documentation was issued as part of the transfer, including a letter of referral with a list of current medications and a resident transfer form. As the transfer was in an emergency, communications with the receiving facility were documented and followed up with a written referral. Copies of all relevant documentation were retained in the resident’s clinical file.

A checklist was not completed by the approved centre to ensure that comprehensive resident records had been transferred to the hospital.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services, which included provisions relating to the response to medical emergencies. It was last reviewed in December 2017. The policy and procedures addressed requirements of the Judgement Support Framework, with the exception of the referral process for residents’ general health needs.

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 the provision of general health services and the response to medical emergencies, as set out in the policy.

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored. 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, which was located in the clinical room. Staff had access at all times to an Automated External Defibrillator, which was in the nurses’ station. Weekly checks were completed on the emergency equipment. Records were available of any medical emergency in the approved centre and of the care provided.

Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis, as part of the approved centre’s provision of care. Residents’ clinical files indicated that they received appropriate general health care interventions in line with needs identified in their individual care plans.

Residents’ general health needs were monitored and assessed at least every six months, and physical assessments included blood analysis and other tests. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents had
access to applicable national screening programmes and were encouraged and facilitated to engage with these. Information regarding screening programmes was available.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in December 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the 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: Residents were provided with an information booklet at admission, which contained information on housekeeping arrangements, including arrangements for personal property, mealtimes, and visiting times and arrangements. The booklet did not reference relevant advocacy and voluntary agencies or residents’ rights; however, information regarding advocacy and voluntary agencies was available in a separate information folder. Residents were also provided with details of their multi-disciplinary team.

Not all residents had access to written and verbal information regarding their diagnosis. Written information relating to a diagnosis of dementia was available, but it dated to 2012. Staff were unable to locate information on the diagnosis of mental health disorders other than dementia and were unaware of how to source or access such information. Written information on diagnosis was not always provided to residents who did not have a diagnosis of dementia.
Information was provided to residents on the likely adverse effects of treatments, including risks and other potential side-effects, in a format appropriate to resident needs. Medication information sheets included evidence-based information on indications for use of all medications administered to residents.

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

a) Written information relating to residents’ diagnosis was not provided to residents who did not have a diagnosis of dementia, 20(1)(c).
Regulation 21: Privacy

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

INSPECTION FINDINGS

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

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: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were appropriately dressed and sought permission before entering residents’ rooms. Residents wore clothing that respected their privacy and dignity. All bathrooms, showers, and toilets had locks on the inside of their doors unless there was an identified risk to residents. Locks had an override facility. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

There were no locks on the inside of the single bedroom doors. The observation panel on the door of one single bedroom was not appropriately screened.

The approved centre was non-compliant with this regulation because the observation panel on the door of one single bedroom was not appropriately screened, which was not conducive to resident privacy.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in May 2017. It addressed all of the requirements of the Judgement Support Framework, but it did not reflect the approved centre’s facilities.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene audit. It had completed a ligature audit using a validated audit tool. Documented analysis had been undertaken to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and to appropriately sized communal rooms. Communal areas were adequately lit to facilitate reading and other activities. The approved centre was comfortably heated at the time of inspection. Rooms were centrally heated, and heating could be controlled in the residents’ rooms.

Appropriate signage and sensory aids were not in place to support resident orientation needs. Only two doors had appropriate visual signage, and one of these was the locked staff toilet. This was a source of potential confusion for residents who could not access the room. The garden was not well maintained and
contained broken items and uneven surfaces. Ligature points had not been minimised and were evident throughout the approved centre. Not all of the residents were categorised as low risk for ligatures because the approved centre admitted residents with major mental illnesses in addition to individuals with a diagnosis of dementia. The ligature audit did not take into account residents with major mental illness.

The approved centre was in a good state of repair throughout. The interior was well maintained, but the exterior gardens were not. There was no programme of routine decorative maintenance. It was reported that there was routine general maintenance of water tanks and fire alarms. No documentation was available in relation to the repair of assistive equipment.

There was an appropriate maintenance reporting process, but there had been unexplained delays in relation to repairing a broken shower and toilet in the approved centre. A cleaning schedule was implemented within the approved centre, which was generally clean and free from offensive odours.

The following issues were identified on inspection:

- Stained windows.
- Rusty shower chairs in a shared bathroom.
- A rusty commode in a shared bathroom.
- A stained sputum bowl in a shared bathroom, which presented an infection-control risk.

There was a sufficient number of toilets and showers for residents in the approved centre. Toilets were accessible but not clearly marked. Wheelchair accessible toilet facilities were not identified for use by visitors who required such facilities.

The approved centre did not have dedicated therapy/examination rooms. There was an activity room, but it was locked on the four days when the activity nurse was not present. The approved centre could only be accessed using both a key and a keypad code.

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

a) There was no record of a programme of routine maintenance and renewal of the fabric and decoration of the premises, 22(1)(c).

b) The condition of the physical structure and the overall approved centre environment was not 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, as evidenced by the presence of ligature points. 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in December 2017. It addressed all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. Staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. There was no evidence to indicate that all staff had training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken. Incident reports were recorded for medication incidents, errors, and near misses, but it was not clear when the incidents occurred because there was no year recorded on the summary of incidences. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: An MPAR was maintained for each resident, and six of these were inspected. Two appropriate resident identifiers were recorded on each MPAR. Names of medications were written in full, and the Medical Council Registration Number of every medical practitioner prescribing medication to residents was included.

The following issues were identified in relation to the MPARs:

- One MPAR did not have a completed allergy section.
- In one MPAR, the generic names of medications were not used.
- In two MPARs, micrograms were abbreviated and not written in full.
- In four MPARs, a record of all medications administered to the residents had not been maintained.
- In two MPARs, the date of discontinuation was not recorded for each medication.
Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident’s care or condition, and this was documented in the clinical file. In three of the MPARs where there was an alteration in the medication order, the medical practitioner did not rewrite the prescription. All medicines were administered by a registered nurse or registered medical practitioner.

The expiry dates of medications were checked prior to their administration, and good hand-hygiene and cross-infection control techniques were observed during the dispensing of medication. Schedule 2 controlled drugs were checked by two staff members, including one registered nurse, and appropriately entered into the controlled drug book.

Directions to crush medication were only accepted from a resident’s medical practitioner. At the time of inspection, however, crushed medication was being administered covertly to one resident who had refused medication. There was no documentation in the clinical file to indicate whether the resident in question had capacity to refuse medication.

Where a resident’s medication was withheld, this was documented in the MPAR but, in one case, it was not recorded in their clinical file. Where a resident refused medication, this was documented in the MPAR but not in the clinical file, and it was not communicated to medical staff.

Medication was stored in the appropriate environment in the approved centre. Where medication required refrigeration, a log of the fridge temperature was taken daily. Medication storage areas were clean and tidy, and food and drink were not stored in areas used for the storage of medication. Medication dispensed to residents was stored securely within the approved centre, and schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. A system of stock rotation was in place to avoid accumulation of old stocks of medication. An inventory of medication was conducted on a monthly basis, but it did not specify the name and dose of medication.

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

- a) One resident had received medication covertly without the completion of a capacity assessment.
- b) One MPAR did not have a completed allergy section.
- c) In two MPARs, the date of discontinuation was not recorded for each medication.
- d) In four MPARs, a record of all medications administered to the residents had not been maintained.
Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.
(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre used the Mayo Mental Health Services policy in relation to the health and safety of residents, staff, and visitors, which was last reviewed in November 2017. It also had a site-specific safety statement. The policy and safety statement addressed all of the requirements of the Judgement Support Framework.

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

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

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

The approved centre was compliant with this regulation.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre used the HSE’s staffing policy in relation to its staffing requirements. The policy was last reviewed in July 2017. It 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: 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 relating to staffing, as set out in the policy.

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

Evidence of Implementation: The staffing policy contained an organisational chart identifying the leadership and management structure and lines of authority and accountability of staff in the approved centre. A planned and actual staff rota, showing the staff on duty during the day and at night, was in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staff were sufficient to address the assessed needs of residents.
The approved centre had a written staffing plan, and annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile.

Orientation and induction training had been completed by all staff. Staff had received training in manual handling, infection control and prevention, dementia care, residents’ rights, risk management, caring for residents with an intellectual disability, and the protection of children and vulnerable adults. Not all medical staff had received training in incident reporting and documentation. They had not been trained in recovery-centred approaches to mental health care and treatment. All staff training was documented.

Not all health care professionals had up-to-date, mandatory training in fire safety, the management of aggression and violence, and the Mental Health Act 2001 and Children First. They had up-to-date training in Basic Life Support.

The Mental Health Act, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Anne’s Unit</td>
<td>CNM3</td>
<td>0.50</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Activation Nurse</td>
<td>0.60</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.25</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.50</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Pharmacist</td>
<td>0.25</td>
<td></td>
</tr>
</tbody>
</table>

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 fire safety and the management of aggression and violence, and the Mental Health Act 2001, 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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in October 2017. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

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

The policy and procedures did not address the process for making a retrospective entry in 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: Residents’ records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were not included in the review process. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were up to date and in good order and were constructed, maintained, and used in line with national guidelines and legislative requirements. Resident’s clinical files were stored in the nurses’ station.
A record had been initiated for every resident in the approved centre, and these were reflective of residents’ current status and the care and treatment being provided. Resident records were maintained through the use of an identifier that was unique to the resident. Resident records were developed and maintained in a logical sequence, and only authorised staff made entries in them.

Residents’ records were stored in an open trolley in the nurse’s station, which was observed to be unlocked and unsupervised at times over the course of the inspection. As a result, the records were accessible to unauthorised staff and were not secured from loss or destruction, tampering, or unauthorised use.

Records were written legibly and contained factual, consistent, and accurate entries. Some entries did not note the time using the 24-hour clock. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was non-compliant with this regulation because residents’ records were not stored in a safe and secure place, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had an electronic register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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

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 April 2017. It 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 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 not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Operating policies and procedures were communicated to relevant staff.

All of the operating policies and procedures required by the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Generic policies in use were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre had a written statement to this effect, adopting the policies in question.

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 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There was a nominated individual with responsibility for dealing with all complaints, who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. The ways in which residents and their representatives
could lodge verbal or written complaints were detailed in the complaints policy and the resident information booklet. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. There had been one minor verbal complaint since the last inspection, and it was dealt with immediately within the approved centre and documented in the complaints log. Since the last inspection, no complaints had required escalation to the nominated person with responsibility for complaints.

Details of complaints and of subsequent investigations and outcomes were fully recorded and kept distinct from residents’ individual care plans.

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 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to risk management and incident management procedures: The Mayo Mental Health Services risk management policy, which was dated November 2017, and the HSE’s risk management policy. Together, the policies addressed requirements of the Judgement Support Framework, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of the following risks:
  
  - Organisational risks.
  
  - Structural risks, including ligature points.
  
  - Health and safety risks to the residents, staff, and visitors.
  
  - Risks to the resident group during the provision of general care and services.
  
  - Risks to individual residents during the delivery of individualised care.

- 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 include the process for identification, assessment, treatment, reporting, and monitoring of 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:** Responsibilities were allocated at management level to ensure the effective implementation of risk management. The person with responsibility for risk was known by all staff in the approved centre.

Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register. Structural risks, notably multiple ligature points, had not been removed or effectively mitigated. The risk register did not highlight the issue of multiple ligature points and the ligature audit has not been updated to reflect the change in resident profile from mainly dementia to including residents with major mental illnesses.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, before and during the use of physical restraint, and in conjunction with medication requirements or administration. The multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required. Residents and/or their representatives were not involved in individual risk management processes.

Incidents in the approved centre were recorded and risk-rated using the National Incident Management System. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission. The approved centre had an emergency plan that incorporated fire evacuation procedures.

**The approved centre was non-compliant with this regulation because the risk management policy was not being implemented in that ligature risks were not mitigated, 32(1).**
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
Regulation 34: Certificate of Registration

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

**INSPECTION FINDINGS**

The approved centre had an up-to-date certificate of registration, which was displayed prominently on the premises.

The approved centre was compliant with this regulation.
None of the rules under the Mental Health Act 2001 were applicable during this inspection.
Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable during this inspection.
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

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in May 2017, addressed all of the policy-related criteria for this code of practice. These included a procedure for involuntary admission, a protocol for planned admissions and a policy on privacy, confidentiality and consent.

Transfer: The transfer policy, which was last reviewed in June 2017, addressed all of the policy-related criteria for this code of practice, including the procedure for involuntary transfer and the way in which a transfer is arranged.

Discharge: The discharge policy, which was last reviewed in June 2017, addressed all of the policy-related criteria for this code of practice. These included procedures for the discharge of involuntary patients and the management of discharge against medical advice and protocols for discharging homeless people.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission and discharge policies but not the transfer policy.

Evidence of Implementation:

Admission: There were no written admission criteria for the approved centre, and there was no clear strategic plan for the future of the resident profile available at the time of inspection.

One clinical file was inspected in relation to admission. The approved centre had a key worker system in place. The resident was admitted to the unit most appropriate to their needs. The resident was assessed at admission, and details of all assessments were documented in the clinical file.

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

Discharge: One clinical file was examined in relation to discharge. The resident’s individual care plan contained a discharge plan. The resident was comprehensively assessed prior to discharge, and a discharge meeting attended by the resident, key worker, and members of the multi-disciplinary team was held. The resident’s GP was informed of the discharge within 24 hours, and there was follow-up from the
community psychiatry of old age team. A comprehensive discharge summary was issued within one day of the discharge.

The approved centre was non-compliant with this code of practice because an audit had not been completed on the implementation of and adherence to the transfer policy, 4.19.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 8: Resident’s Personal Property and Possessions

*Report reference: Page 22-23*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resident were not supported to manage their own property and were not assessed in relation to any risks associated with retaining control over their personal property and possessions, 8(5).</td>
<td>Corrective Action(s): A new section to be added to Initial Care Plan in order to support residents to manage own property &amp; possessions. Risk assessment to be completed as required. Post-Holder(s) responsible: CNM3 T Garrett</td>
<td>Quarterly ICP audit.</td>
<td>Achievable</td>
<td>31st Oct 2018</td>
</tr>
<tr>
<td>New</td>
<td>Preventative Action(s): Implement new ICP Post-holder responsible: T Garrett CNM3</td>
<td>Annual audit and analysis</td>
<td>Achievable</td>
<td>Audit - March 2019</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------</td>
<td>-------------</td>
<td>-----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>1. No evidence of resident involvement in the ICP review process/no documented evidence of assessment of resident’s functional capacity before the decision was made not to engage the resident in the process.</td>
<td>Corrective Action(s): 1. Update ICP review form to include section on residents involvement and any reasons for non-involvement. Post-Holder(s) responsible: CNM2 (BR) Preventative Action(s): Update of ICP monthly review form to include individual numbered goals. Post-Holder(s) responsible: CNM2 CNM3</td>
<td>Quarterly Audits of ICP’s</td>
<td>Achievable</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; Oct 2018</td>
</tr>
<tr>
<td>2. No clear evidence that the ICP was updated based on a review of progress aimed at addressing resident goals.</td>
<td>Corrective Action(s): Post-Holder(s) responsible:  a) Update of ICP monthly review form to include individual numbered goals. Preventative Action(s): Implement of ICP review form. Post-Holder(s) responsible:</td>
<td>Quarterly Audits of ICP’s</td>
<td>Achievable</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implementation of new review form.</td>
<td>Achievable</td>
<td>Completed</td>
</tr>
</tbody>
</table>
| 3. No evidence that residents were offered a copy of their ICP and a reason for this was not recorded | **Reoccurring** | Corrective Action(s):  
Update ICP review form to include section on copy offered to residents.  
Post-Holder(s) responsible: CNM2 (BR) | Quarterly Audits of ICP’s | Achievable | 31st Oct 2018 |
| Preventative Action(s):  
Implement of ICP review form.  
Post-Holder(s) responsible: CNM2/CNM3 | Quarterly Audits of ICP’s | Achievable | 31st Oct 2018 |
### Regulation 20: Provision of information to residents

**Report reference: Page 37-38**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Written information relation to resident’s diagnosis was not provided to residents who did not have a diagnosis of dementia, 20(1)(c).</td>
<td>New</td>
<td>Corrective Action(s):&lt;br&gt;Post-Holder(s) responsible:&lt;br&gt;The key worker will provide written and verbal information to the residents and a new section regarding residents diagnosis will be added to the ICP. This information will be sourced through the Choice Medication Link.</td>
<td>Annual audit of Reg 20</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s):&lt;br&gt;Post-Holder(s) responsible:&lt;br&gt;Each Key-worker. Monitored by CMN2.</td>
<td>Annual audit of Reg 20</td>
<td>Achievable</td>
<td>May 2018 To be re-audited in September 2018</td>
</tr>
</tbody>
</table>
## Regulation 21: Privacy

**Report reference: Page 39**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. The observation panel on the door of one single bedroom was not appropriately screened, which was not conducive to resident privacy.</td>
<td>New Corrective Action(s): Replace broken screen on door. Post-Holder(s) responsible: Maintenance department.</td>
<td>Annual audit and analysis of Reg 21</td>
<td>Achievable</td>
<td>Completed</td>
</tr>
<tr>
<td>Preventative Action(s): Annual audit and analysis of Reg 21</td>
<td>Audit and analysis. Walk Through with Registered Proprietor (16th March 2018)</td>
<td>Achievable</td>
<td>Completed</td>
<td></td>
</tr>
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### Regulation 22: Premises

**Report reference: Page 40-41**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. No record of a programme of routine maintenance and renewal of the fabric and decoration of the premises, 22(1) (c).</td>
<td><strong>Corrective Action(s):</strong>&lt;br&gt;1. An annual audit of premises is routinely completed, by senior management and maintenance staff.&lt;br&gt;2. A maintenance and decoration log is kept and updated regularly.&lt;br&gt;&lt;br&gt;<strong>Post-Holder(s) responsible:</strong>&lt;br&gt;1. As above&lt;br&gt;2. CNM2</td>
<td>Annual audit</td>
<td>Achievable</td>
<td>Completed 24th April 2018</td>
</tr>
<tr>
<td></td>
<td><strong>Preventative Action(s):</strong>&lt;br&gt;Annual Audit and regularly review of log.</td>
<td>Annual audit</td>
<td>Achievable</td>
<td>As above</td>
</tr>
<tr>
<td>7. The condition of the physical structure and the overall AC environment was not developed and maintained with due regard to the specific needs of resident and patients and the safety and well-being of residents, staff and</td>
<td><strong>Corrective Action(s):</strong>&lt;br&gt;With effect from 03/09/18 only Service Users with a diagnosis of dementia will be admitted, therefore lowering risk ratings.&lt;br&gt;Rusty &amp; dirty items removed. Window cleaning scheduled.&lt;br&gt;&lt;br&gt;<strong>Post-Holder(s) responsible:</strong>&lt;br&gt;Admitting Consultants, CNS in Infection Prevention and Control, CNM 2’s.</td>
<td>Ligature audit to be repeated in light of new admission criteria then reviewed annually thereafter. Annual Environmental Audit &amp; monthly cleaning audits.</td>
<td>Achievable</td>
<td>Completed 05/10/18</td>
</tr>
</tbody>
</table>
visitors, as evidenced by the presence of ligature points and infection-control issues, 22(3).

Preventative Action:
To remain on Business Meeting agenda & local Risk register
Continue to monitor all patients with high risk ratings (following risk assessment) & review at MDT.
Increase level of 1:1 observations if appropriate
Monthly cleaning audits commenced July 2018
Post-Holder(s) responsible:
As above

Quarterly Business meetings
Achievable
05/10/18 and on-going

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. One resident had received medication covertly without the completion of a capacity assessment.</td>
<td>New</td>
<td>Corrective Action(s): 1. Medication management policy to be updated to detail process for covert administration as per Maudsley guidelines. 2. Clinical Pharmacist review for change of medication formulation and</td>
<td>Quarterly audit of PMARs, Clinical pharmacist attendance at MDT upon request and where necessary including review of PMARs.</td>
<td>Achievable</td>
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</table>
|   | administration form to be developed and included in policy.  
Post-Holder(s) responsible: Selina McGreal (MPSI), D&T, policy steering group |   |   |
|   | Preventative Action(s): Medication management policy to be read by all relevant staff and implemented.  
Post-Holder(s) responsible: Relevant staff prescribing and administering medication |   | N/A |
| 9. | One MPAR did not have a completed allergy section.  
10. Two MPARs, the date of discontinuation was not recorded for each medication  
11. Four MPARS, a record of all medications administered to the residents had not been maintained. | Corrective Action(s):  
1. NCHD induction training provided to emphasise importance of completion of allergy status.  
2. Medication management training provided to CNMs to encourage non-administration of medication when allergy status is incomplete.  
3. Pharmacist to review PMARs (returned from uncovered maternity leave)  
Post-Holder(s) responsible: Selina McGreal (MPSI) | Quarterly audit of PMARs, analysis and feedback to staff by Clinical Pharmacist.  
Achievable | Completed 10/07/2018  
Completed 18/04/2018 |
|   | Preventative Action(s): Quarterly audits on PMAR to recommence to monitor prescribing and administration.  
Post-Holder(s) responsible: Selina Mcgreal (MPSI) & Martin Doyle Training Officer |   | Completed Aug 2018 |
### Regulation 26: Staffing

**Report reference: Page 45-46**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Not all staff had up-to-date mandatory training in fire safety and the management of aggression and violence and, as such did not have access to training and education to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).</td>
<td><strong>Reoccurring</strong> Corrective Action(s): Following the annual training needs analysis, mandatory training is ongoing and a list of dates have been scheduled for Autumn 2018. Post-Holder(s) responsible: CNM3 Preventative Action(s): Review training Monthly Post-Holder(s) responsible: CNM3</td>
<td>Annual Staffing audit.</td>
<td>Achievable</td>
<td>Ongoing</td>
</tr>
<tr>
<td>13. Not all staff had up-to-date, mandatory training in the Mental Health Act 2001, 65(5).</td>
<td></td>
<td>Monthly reviews</td>
<td>Achievable</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
## Regulation 27: Maintenance of Records

**Report reference: Page 47-48**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 14. Residents’ records were not stored in a safe and secure place, 27(1).                 | Corrective Action(s): Residents records are now stored in a locked nurse office.  
Post-Holder(s) responsible: CNM2’s                                                       | Audit of Maintenance of records (completed 16/5/18)                        | Achievable             | Completed   |
| Preventative Action(s):  
Post-Holder(s) responsible: Monitored by CNM2’s                                      |                                                                          |                                                                          |                        |            |
|                                                                          |                                                                          |                                                                          |                        |            |
|                                                                          |                                                                          |                                                                          |                        |            |
## Regulation 32: Risk Management Procedures

### Area(s) of non-compliance

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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</tr>
</thead>
<tbody>
<tr>
<td>15. The risk management policy was not being implemented in that ligature risks were not mitigated 32(1).</td>
<td>Corrective Action(s): Repeat ligature audit in view of new admission criteria. With effect from 03/09/18 only Service Users with a diagnosis of dementia will be admitted, therefore lowering risk ratings. Ligature anchor points identified will have an action plan in place to mitigate the risk as low as reasonably practicable. Ligature anchor risks will be populated onto ST Annes Unit Risk Register.</td>
<td></td>
<td></td>
<td>Completed 05/09/18</td>
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<tr>
<td></td>
<td>Post-Holder(s) responsible: MDT – co-ordinated by CNM3 T Garrett</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Preventative Action(s): Implement Risk Management Policy &amp; monitor</td>
<td>As above</td>
<td>As above</td>
<td>Completed 05/09/18</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: T Garrett CNMIII</td>
<td></td>
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### Reoccuring

- Quarterly Business Meeting and availability of minutes
- Risk Register will provide mechanism for monitoring action plan.
### Code: Admission, Transfer and Discharge

**Report reference: Page 60-61**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. An audit had not been completed on the implementation of and adherence to the transfer policy, 4.19.</td>
<td><strong>Reoccurring</strong> Corrective Action(s): Complete Audit Post-Holder(s) responsible: CNM2</td>
<td>Audit</td>
<td>Achievable</td>
<td>Completed 2/5/18</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Annual Audit Post-Holder(s) responsible: CNM3</td>
<td>As above</td>
<td>Achievable</td>
<td>Completed</td>
</tr>
</tbody>
</table>