Maryborough Centre, St. Fintan's Hospital

ID Number: AC0008

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Maryborough Centre, St. Fintan's Hospital
Dublin Road
Portlaoise
Co Laois

Approved Centre Type:
Continuing Mental Healthcare/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
17 May 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Dervila Eyres, General Manager, CHO8

Inspection Team:
Mary Connellan, Lead Inspector
Leon Donovan
Martin McMenamin

Inspection Date:
29 May –1 June 2018

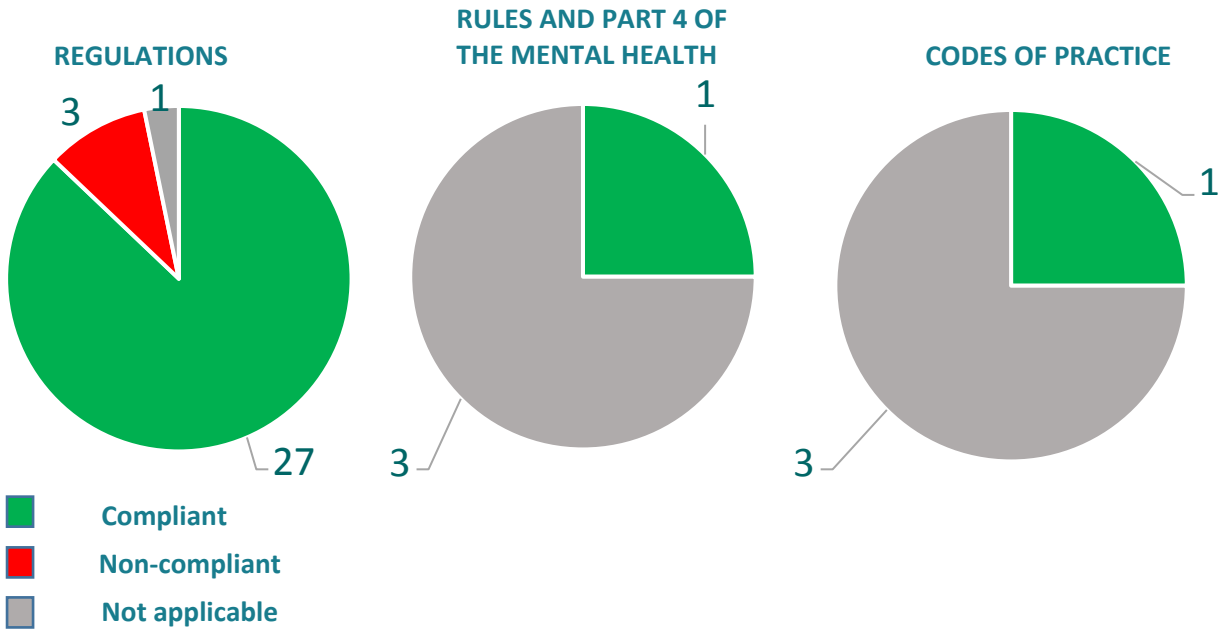
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
28 February – 3 March 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
25 October 2018

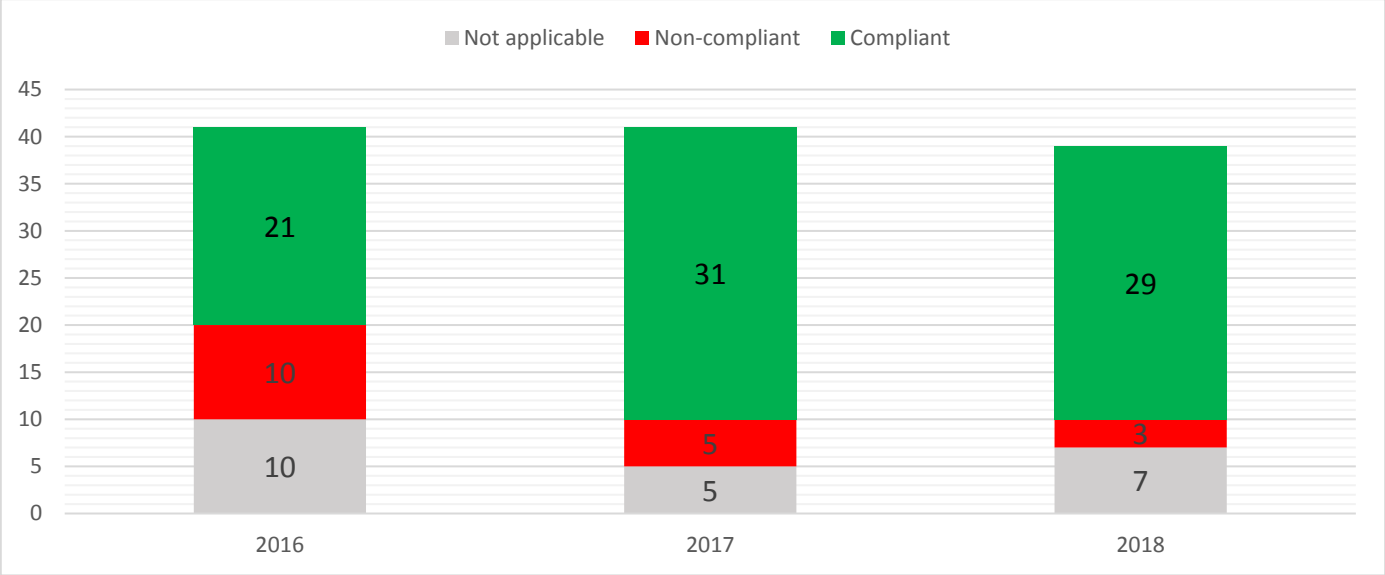
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

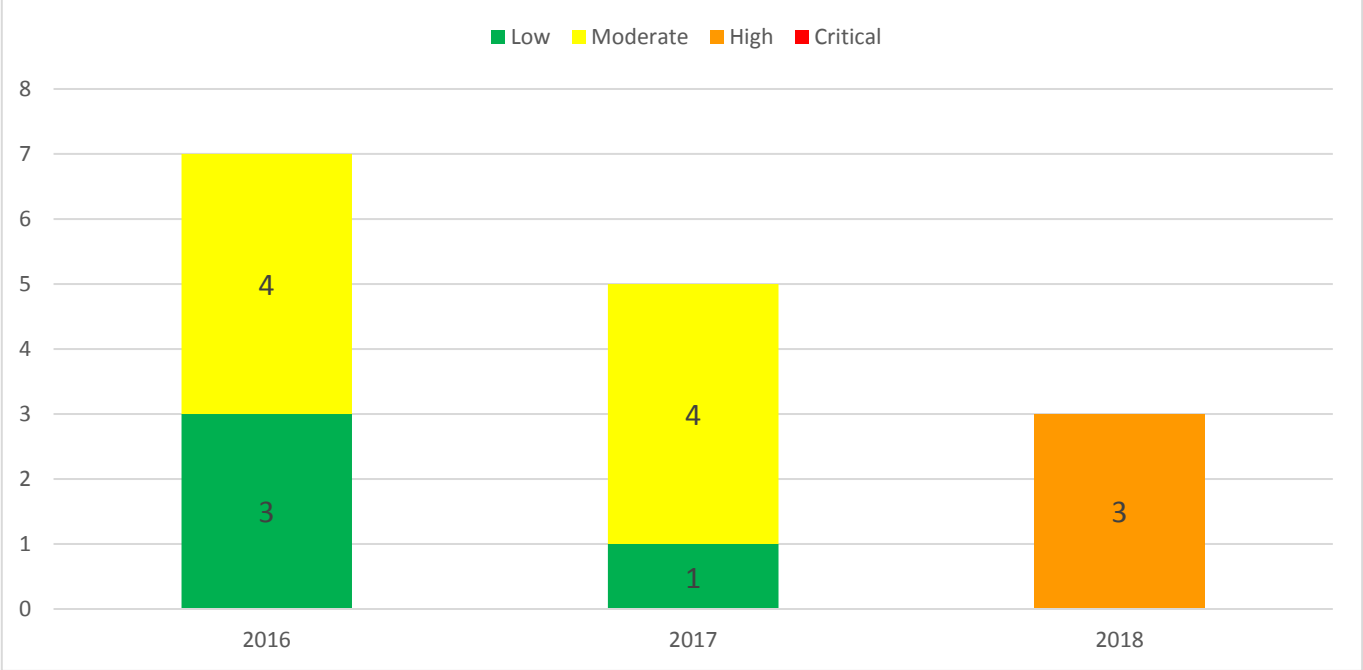
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018



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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".

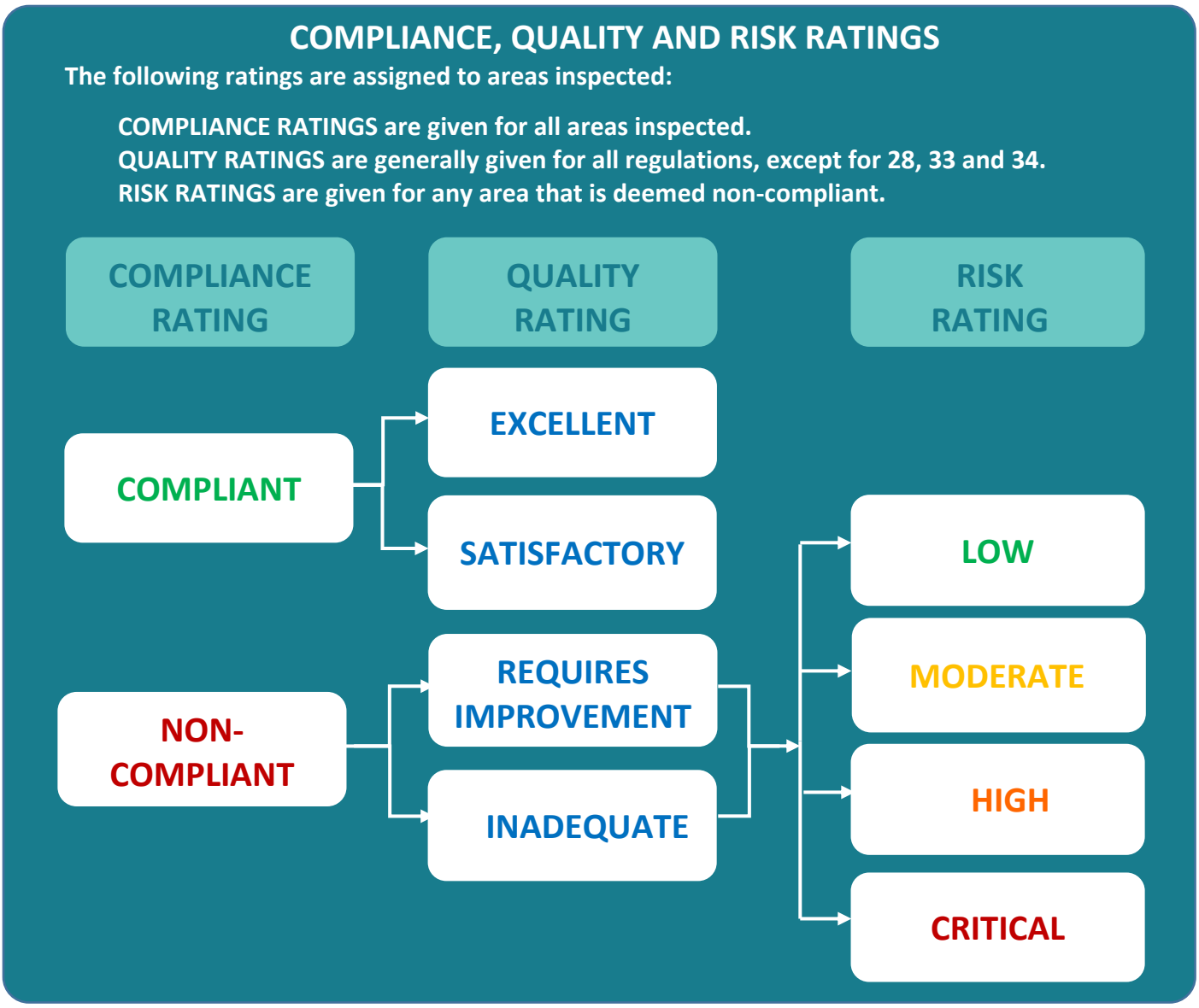
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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 – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

Maryborough Centre was located in St Fintan's Hospital, Portlaoise. It is the only inpatient facility in the Victorian building of St Fintan's hospital, despite national policy of closing 19th century asylums. The door was locked at all times. It was registered for 30 beds. There were 25 residents at the time of inspection. The approved centre was registered to provide continuing care, psychiatry of later life and mental rehabilitation services. However, with locked doors, the 19th century building and large number of residents with differing needs is part of a bygone age of providing mental health care with associated stigma. Added to this was the lack of therapeutic services and programmes and the staff to provide them. Despite this, people continued to be admitted to the approved centre.

The approved centre had shown continuous improvement in compliance with Regulations, Rules and Codes of Practice: there was 68% compliance in 2016, increasing to 91% in 2018. Five areas of compliance were rated excellent.

Safety in the approved centre

Food safety was adequate. Medication was ordered, prescribed, stored and administered in a safe manner. Not all health care professionals had up-to-date, mandatory training in Basic Life Support, fire safety, Therapeutic Management of Violence and Aggression or equivalent and Children First. Risk management process were satisfactory.

Appropriate care and treatment of residents

For residents with physical needs, the estimated waiting time for assessment by a community based primary care occupational therapist was up to two years, which was entirely unacceptable. One resident was waiting for a seating assessment from an occupational therapist and this had not been provided. Another referral to occupational therapy for a physical care assessment had been made in July 2017, was being seen at the time of the inspection, ten months later. Non-consultant hospital doctors visited the approved centre but the times were restricted due to other demands and an agreement to outsource physical care to a general practice surgery while agreed in principal had not been commenced.

Five individual care plans (ICPs) did not include appropriate goals for the resident, identify the care and treatment required or identify the resource required to provide care and treatment. While there was evidence of a review of the ICPs at least six monthly, not all were reviewed or updated with input from a wider multi-disciplinary Team. The resident had access to their ICP and was kept informed of any changes. Admission, transfer and discharge procedures were satisfactory.

The range of services and programmes provided in the approved centre was not monitored on an ongoing basis to ensure that the assessed needs of residents were met. There was no mental health occupational therapist or psychologist involved with therapeutic services or programme. There was a reliance on recreational activities, which did provide therapeutic benefit to some of the residents. The budget available for these was considered too small by staff. This lack of therapies was unacceptable.

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

End of Life care was provided in a manner that respected the dignity of the resident and accommodation of family. Palliative care was provided where indicated.

Respect for residents' privacy, dignity and autonomy

Each resident wore their own clothes and had sufficient storage space for their property and possessions. Privacy was provided for visits. The approved centre's layout and furnishings were conducive to resident privacy and dignity but single rooms did not have locks on the inside of the door. Where residents shared a room, appropriate bed screening was in place to ensure that resident privacy was not compromised. Rooms were not overlooked by public areas. Public noticeboards did not display residents' names or any identifiable information.

Responsiveness to residents' needs

Residents had access to a range of appropriate recreational activities. These included baking, music, walks, weekend outings, art and exercise groups as well as access to an outdoor garden. Recreational activities were facilitated on weekdays and during the weekend. There was a large day area and an activities room where activities were held. There was an element of choice in the meals provided. There were no restrictions on communication.

Written information about the approved centre, medication and diagnosis was available and the complaints procedure was robust.

The approved centre was kept in a good state of repair externally and internally and it was clean, hygienic, and free from offensive odours. Heating could not be controlled in the resident's own room. There was a sufficient number of toilets and showers for residents in the approved centre. All resident bedrooms were appropriately sized to address the resident needs.

Governance of the approved centre

The approved centre was under the governance and management of Community Healthcare Organisation 8 (CHO 8). A monthly leadership meeting included representatives from heads of discipline, human resources, administration and finance and clinical directors. A Laois-Offaly Senior Management Team Meeting was held monthly that included representatives from the approved centre, the general manager and administrative staff and other associated allied health professionals. At the time of the inspection, the position of Risk and Patient Safety Advisor was vacant.

The approved centre together with the Department of Psychiatry located in Portlaoise Midland Hospital held fortnightly governance meetings. This was also the forum adopted for the development of the policies and procedures relating to the two approved centres but there was minimal documentation of this in the minutes of the meetings. A drugs and therapeutics meeting took place every six weeks.

Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register.

With the exception of the executive clinical director, all other heads of discipline were newly appointed or in a temporary position. The heads of discipline for the allied health professional group did not routinely visit the approved centre and at the time of the inspection, there was no dedicated occupational therapist or psychologist for the residents, which was an operational risk. The lack of a specialist psychologist prevented recently appointed trainee psychologists being placed in the approved centre.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A 0.5 WTE (whole time equivalent) pharmacy technician has been employed by the approved centre and provided a stock check, rotation and top-up service to the approved centre.

2. The Maryborough Nutritional group in conjunction with the catering department had revised the menus and improved the choice of food options for the residents. A patient satisfaction survey relating to the food had been completed. Menus for the dining room tables had also been introduced.

3. A weekly staff meeting had commenced in the approved centre.

4. Resident community meetings had been initiated and documented and were held every two weeks.

5. A training database had been developed with training scheduled in six-month blocks. A training group were meeting twice yearly.

6. The Support and Advocacy Service (SAGE) visited the approved centre on request. Their contact details were displayed prominently in the approved centre.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located in St Fintan's Hospital, Portlaoise. Formally known as Ward 6, the name had been changed to the Maryborough Centre drawing on the history of Portlaoise dating back to the 16th century. Although the only inpatient facility at St Fintan's hospital, the approved centre was located alongside a child and adolescent service, primary care services and two other mental health services. While registered for 30 beds, following extensive upgrading and refurbishment, the approved centre had reduced the number of beds to 28. On the first day of the inspection there were 24 residents increasing to 25 on a subsequent day with an admission.

The approved centre was registered to provide continuing care, psychiatry of later life and mental rehabilitation services. There were four residents under the care of the Rehabilitation team with the remaining 21 under the care of the Psychiatry of Later Life team. While the majority of residents were in continuing care, the resident cohort had changed since the previous inspection. Twenty-three individuals had been admitted to the approved centre, ten had been discharged home or to another facility. Five of these had been admitted within the previous month. Ten residents had died since the last inspection. One resident had a diagnosis of an intellectual disability.

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

Resident Profile	
Number of registered beds	***30***
Total number of residents	**24**
Number of detained patients	1
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	21
Number of patients on Section 26 leave for more than 2 weeks	0

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 under the governance and management of Community Healthcare Organisation 8 (CHO 8). This encompassed Laois-Offaly and Longford-West Meath sectors. A monthly leadership meeting included representatives from heads of discipline, human resources, administration and finance and clinical directors.

There was a Laois-Offaly Senior Management Team Meeting also held monthly that included representatives from the approved centre, the general manager, administrative staff, and other associated allied health professionals. This served the wider mental health services in those counties. Quality and Risk was a standing item for discussion at these meetings. At the time of the inspection, the position of Risk and Patient Safety Advisor was vacant.

The approved centre together with the department of psychiatry located in Portlaoise Midland Hospital held fortnightly governance meetings. This was also the forum adopted for the development of the policies and procedures relating to the two approved centres. While it was evident that agenda items and actions were discussed, only one set of the most recent minutes clearly showed this. It was also evident that the policies and procedures had been developed from this group with input from relevant stakeholders; however, documentary evidence was minimal.

A drugs and therapeutics meeting took place every six weeks.

The inspection team sought to meet with all heads of discipline during the inspection. The inspection team met with the following individuals:

- Executive Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Principal Psychology Manager
- Temporary Principal Social Worker

With the exception of the executive clinical director, all other heads of discipline were newly appointed or in a temporary position. The executive clinical director and area director of nursing were based half of the time in the approved centre and were very familiar with the staff and daily routines of the approved centre. The heads of discipline for the allied health professional group did not routinely visit the approved centre and at the time of the inspection, there was no dedicated occupational therapist or psychologist for the residents.

The heads of discipline had very clear strategic aims focussing on the development of the service for the resident cohort. It was generally felt that these residents were a specialist group with complex psychosocial and physical needs. The lack of specialist occupational therapy and psychology were noted as operational risks. Furthermore, for those residents with physical needs the estimated waiting time for assessment by a community based primary care occupational therapist was up to two years. The lack of a specialist psychologist prevented recently appointed trainee psychologists being placed in the approved centre.

Non-consultant hospital doctors visited the approved centre as part of their rotation on the Psychiatry of Later Life and Rehabilitation teams. The times were restricted due to other demands and an agreement to outsource physical care to a general practice surgery while agreed in principal had not been commenced. The inspection team understood that non-consultant hospital doctors were to increase their time directly spent in the approved centre.

For all disciplines, there were clearly defined line management and escalation processes. The heads of discipline had received training on clinical risk management, National Incident Management (NIM's) and health and safety. Each discipline met either weekly or monthly and each had a forum for individual or peer supervision although this was not active amongst nursing staff. There was evidence of continuous professional development for each discipline either in group format or individual according to needs.

4.5 Use of restrictive practices

The front door was locked at all times and was opened by staff using a keypad. This was a mechanism to ensure the safety and welfare of the residents, and as a means of security.

5.0 Compliance

5.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 15: Individual Care Plan	✓		✓		✗	High
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	High
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 7: Clothing
Regulation 10: Religion
Regulation 11: Visits
Regulation 18: Transfer of Residents
Regulation 30: Mental Health Tribunals

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

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

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 inspectors met with four residents and three family members. One completed service user experience questionnaire was returned. All comments were complimentary of the staff and the care and treatment provided. Residents and their relatives were happy with the food and food choices, the bedroom and day facilities, and the recreational activities available to them. The completed questionnaire indicated that the resident was involved in their care planning and goal setting, knew their mental healthcare team and keyworker and was always able to discuss worries or concerns with a member of staff. They also indicated that they felt that they had space for privacy and that their privacy and dignity were respected.

7.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Executive Clinical Director
- Area Director of Nursing
- Chief Pharmacist
- Assistant Director of Nursing
- Assistant Director of Nursing / Compliance Officer
- Occupational Therapy Manager
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x 2
- Consultant Psychiatrist
- Social Work Team Leader
- Business Manager
- Administrator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. These are included in the relevant section of the report.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

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

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not 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 detailed within the residents' clinical files. Identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, providing health care services and therapeutic services and programmes. There was an alert system for identifying 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 monitoring pillar.

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Menus had been approved by a dietitian and residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals and food, including modified consistency diets. Meals were attractive and appealing in presentation. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times. Hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was used for all residents. Where appropriate, weight charts were implemented, monitored, and acted upon. Residents, their representatives, family, and next of kin were educated about residents' diets, where appropriate. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian and intake and output charts were maintained, where appropriate. Nutritional and dietary needs were assessed. However, in one case reviewed, this had not been documented accurately in the resident's individual care plan.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP).

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. There was suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, and serving of food. Food was prepared and cooked in the main kitchen of the Midlands Regional Hospital and not in the approved centre.

Hygiene was maintained to support food safety requirements, and associated catering and food safety equipment were appropriately cleaned. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes at the time of inspection unless they were being nursed in bed.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents' clothing was clean and appropriate to their needs and residents had access to on-site laundry facilities. Emergency clothing was available if it was required. Residents changed out of nightclothes during the day unless they were being cared for in bed. All residents had an adequate supply of individualised clothing.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in December 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of valuables and personal effects. Access to and use of resident monies was overseen by two staff members and, when possible, the resident or their representative.

Each resident had their own wardrobe and personal effects in their room. Individual property checklists were maintained. These were filed separately to each resident's individual care plan and were available to residents.

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 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to a range of appropriate recreational activities. These included baking, music, walks, weekend outings, and art and exercise groups. Residents also had access to an outdoor garden. Recreational activities were facilitated on weekdays and during the weekend, and they were developed and implemented with resident involvement. There was a large day area and an activities room where activities were held.

Where appropriate, individual risk assessments had been completed for residents in relation to the selection of activities. Residents' decisions on whether or not to participate in activities were respected and documented.

The recreational activities provided by the approved centre were not appropriately financially resourced. The small monthly budget resulted in some activities being curtailed or deferred at times. Documented records of attendance were retained both within group records and the resident's clinical file.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents were facilitated to practice their religion insofar as was practicable. There was a church on the grounds and mass was celebrated weekly. If required, residents had access to multi-faith chaplains.

The care and services provided in the approved centre were respectful of the residents' religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in March 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: There were no restrictions on residents' rights to receive visitors. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed and were appropriate and reasonable. There were no visiting restrictions for any of the residents. A separate visitors' room was located near the entrance to the approved centre and was suitable for visiting children. The identification of this area ensured residents could meet visitors in private. Visitors were requested to sign a visitors' book. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to resident communication. The policy was last reviewed in The policy and procedures 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 communication, as set out in the policy.

Monitoring: Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to a range of communications, including telephone. When necessary, individual risk assessments were completed for residents with regard to their communication.

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

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in March 2017. 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: 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 no search had been conducted in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not applicable.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and protocols in relation to care of the dying. The policies were last reviewed in May 2016 and April 2018. The policies and protocols addressed requirements of the *Judgement Support Framework*, with the exception of the process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health services).

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

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

Evidence of Implementation: Ten residents had died in the approved centre since the last inspection. The clinical file of one resident who had died was reviewed. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of the resident, who was nursed in a single room. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Palliative care was prioritised and the palliative care team attended as required. A Do Not Attempt Resuscitation (DNAR) order and associated discussions were documented in the clinical file.

Support was given to other residents and staff following a resident's death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

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

Monitoring: Residents' ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: The ICPs were maintained as one composite set of documents that included spaces or sections for goals, treatment, care and resources required. There was a space or section for reviews and they were stored in the clinical file separate from the progress notes.

Nine ICPs were inspected. Each resident had an initial assessment and an ICP had been developed within seven days of admission. With one team there was evidence that the ICP had been developed with input from medical and nursing staff only. Comprehensive assessments had been completed for each resident using evidence based assessments where possible.

The ICP was drawn up involving the resident. When a resident was unable to participate there was no evidence in the documentation to indicate that the relatives had been involved in the process on behalf of the resident. Five ICPs did not include appropriate goals for the resident, identify the care and treatment required or identify the resource required to provide care and treatment.

A keyworker had been identified for each resident to ensure continuity in the implementation of the ICP. Each included a risk management plan. While there was evidence of a review at least six monthly not all were reviewed or updated with input from a wider MDT. The resident had access to their ICP and was kept informed of any changes.

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

a) **Appropriate goals, treatment and resources were not specified in all the ICPs.**
b) **Not all the ICPs had been developed and reviewed with input from the wider MDT.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in August 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the processes and procedures for the roles and responsibilities in relation to the provision of therapeutic services and programmes.

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

Monitoring: The range of services and programmes provided in the approved centre was not 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 therapeutic services and programmes that were provided were appropriate and evidence based. They met the assessed needs of the residents, as documented in their individual care plans. Services and programmes were not always directed towards restoring and maintaining optimal levels of physical functioning of residents. There was no mental health occupational therapist or psychologist involved with therapeutic services or programme. One resident was waiting for a seating assessment from an occupational therapist and this had not been provided. Another referral to occupational therapy for a physical care assessment had been made in July 2017, was being seen at the time of the inspection ten months later. There was a reliance on recreational activities, which provided therapeutic benefit to some of the residents. The budget available for these was considered too small by staff.

The approved centre was non-compliant with this regulation because the range of therapeutic services and programmes provided was limited and did not ensure the restoration and maintenance of optimal levels of physical functioning of all residents, 16(2).

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was inspected. Communication records with the receiving facility were documented and included the reason for transfer and the resident's care and treatment plan. Documented consent had been received from the resident. The next of kin was informed and involved in the transfer process. An assessment of the resident was completed prior to transfer, including a risk assessment relating to the transfer and the resident's needs.

A letter of referral, including a list of current medications, a transfer form, and a list of required medication for the resident during the transfer process was issued with copies retained as part of the transfer documentation. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. All records relevant to the transfer were retained in the resident's clinical file.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in March 2017. The medical emergencies policy was last reviewed in April 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator, which had been checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents' physical health on admission, and general health needs were managed thereafter. At a minimum, a six-monthly health assessment had been completed. For residents on antipsychotic medication there was evidence of an assessment of glucose regulation, blood lipids and prolactin. These residents had also had an Electrocardiogram (ECG). Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. National screening information was available, and residents could access national screening programmes, as applicable to resident needs.

There was a policy on tobacco use and how smoking cessation was implemented. Nicotine replacement therapy was available and residents were supported to stop smoking.

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 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A resident guide was provided to residents and their representatives at admission, and it included the approved centre's information booklet. This contained details of the housekeeping arrangements such as mealtimes, the complaints procedure, visiting times and arrangements, the arrangements for personal property, and details of a relevant advocacy agency. Residents and their families were provided with information on their Multi-Disciplinary Team (MDT).

Residents and their families received written and verbal information regarding diagnoses and the likely adverse effects of treatment, if applicable. Medication information sheets as well as verbal information were provided, and these included information on indications for use and possible side effects of medication. The information provided by the approved centre was evidence-based and had been appropriately reviewed. If required, residents had access to interpretation and translation services.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in March 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the approved centre's process for addressing a situation where resident privacy and dignity was not respected by staff.

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

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had not 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. Residents wore clothing that respected their privacy and dignity. The approved centre's layout and furnishings were conducive to resident privacy and dignity. Single rooms did not have locks on the inside of the door. Where residents shared a room, appropriate bed screening was in place to ensure that resident privacy was not compromised. Rooms were not overlooked by public areas. Public noticeboards did not display residents' names or any identifiable information.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The approved centre's premises maintenance programme.
- The approved centre's cleaning programme.
- The approved centre's utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The identification of hazards and ligature points in the premises.

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

Monitoring: The approved centre had not completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space that included appropriately sized communal rooms, and to shared space in the form of well-lit and comfortably heated and ventilated communal rooms. There was sufficient space for residents to move about, including an outdoor garden. Appropriate signage and sensory aids were provided to support resident orientation needs in some areas of the approved centre but not throughout. Some minor hazards were noted in the garden including unfinished footpaths. There were wires and drainpipes that were potentially hazardous, however these were cornered off to prevent residents accessing them directly.

Overall the approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was a cleaning schedule and the approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with heating controlled on the one zone. Heating could therefore not be controlled in the resident's own room. Where faults or problems were identified in relation to the premises. Communication was made through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Backup power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. Wheelchair accessible toilet facilities were identified for use by residents and visitors who required such facilities. The approved centre had a designated sluice room, a designated cleaning room, and a laundry room.

All resident bedrooms were appropriately sized to address the resident needs. The approved centre provided suitable furnishings to support resident independence and comfort. Assisted devices and equipment were provided to address resident needs.

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

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to the ordering, storing, prescribing, and administration of medication. The policies were last reviewed in April 2018. The policies included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: An MPAR was maintained for each resident that detailed two appropriate identifiers, a record of any allergies or sensitivities and the generic names of medications prescribed. There were dedicated spaces for routine medications, once-off medications and 'as required' (PRN) medications. The frequency, dose and administration route were included for each prescription. There were clear records of the dates of initiation and discontinuation for each medication, including the medical council registration number and signature of every medical practitioner prescribing. There was a record of all medications administered to the residents.

The entries in the MPARs were legible and written in black, indelible ink. Medication had been reviewed and rewritten at least every six months. All medication had been administered by a registered nurse or registered medical practitioner. No residents were self-administering medication at the time of inspection. Where a resident's medication was withheld, the justification was noted in the MPAR and documented in the clinical file. Directions to crush medication were only accepted from the medical practitioner and the reasons were documented. The pharmacist had been consulted about the type of preparation to be used.

Medication had been stored appropriately and storage areas were clean. A log of temperature of the refrigeration storage unit had been taken and documented daily. Medication was stored securely in a locked unit and scheduled 2 and 3 controlled drugs were kept locked in a separate cupboard. A system of stock rotation had commenced following the recent appointment of a pharmacy technician to the

approved centre. An inventory of all medications was conducted on a monthly basis. Medications that were no longer in use had been returned to the pharmacy for disposal.

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 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in March 2017. It also had an associated safety statement, dated January 2018. The policy and safety statement addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Raising awareness of residents and their visitors to infection control measures
- Covering of cuts and abrasions
- Availability of staff vaccinations and immunisations

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2017. The policy addressed requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre. The policy did not include the following:

- The maintenance of CCTV cameras by the approved centre.
- The process to cease monitoring a resident using CCTV in certain circumstances.

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purpose of ensuring health, safety and welfare. The use of CCTV had been disclosed to the Mental Health Commission and the CCTV cameras were incapable of recording or storing a resident's image.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to its staffing requirements. The policies were last reviewed in June 2017 and March 2018.

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

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

The policies and procedures did not address the following:

- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability of the approved centre's staff. There was a planned nursing staff rota, showing the nursing staff on duty both day and night.

The numbers and skill mix of staff was not sufficient to meet the resident needs. There was minimal input from occupational therapy and there was no psychology input. At the time of inspection, there was an unfilled psychology position at staff grade. It was reported that this also restricted input from psychology trainees. There was no psychiatry of later life mental health occupational therapy available and there was occasional input from the rehabilitation team occupational therapist. Residents were on a waiting list for primary care occupational therapy assessment, and it was stated that they could be waiting for up to two years.

Staff were recruited, selected and vetted in accordance with the approved centres policies and procedures. Staff had appropriate qualifications to do their jobs and an appropriately qualified nursing staff member was on duty and in charge at all times. There was no written staffing plan for the approved centre. There was a minimum required number of nursing staff on duty at night to ensure safety of residents in the event of a fire or other emergency. Agency staff were used and there was a comprehensive agreement between the approved centre and the agency.

Annual training plans had been completed for all staff. Orientation and induction training was provided for new staff. Not all health care professionals were up to date with required mandatory training to include Children First, Fire Safety, Basic Life Support, the Mental Health Act and Therapeutic Management of Violence and Aggression or equivalent. Overall, there had been significant improvements since the last inspection and nursing staff were up to date with both Fire Training and Children First. Other training that had been completed in line with assessed needs of resident group profile included manual handling, dementia care, end of life care and care for residents with an intellectual disability. Staff had been trained in incident reporting. Not all staff were trained in the protection of vulnerable adults. However, this was being arranged by the social work department at the time of the inspection. Opportunities were available to staff for further education and in-service training had been completed by appropriately trained individuals.

The Mental Health Act 2001, the associated regulation and the Mental Health Commission Rules and Codes were available to staff throughout the approved centre.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Maryborough	CNM 2 RPN HCA MTA (Activities)	1 3 3 1	0 3 1 0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA) Multi-Task Attended (MTA)

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

a) **The numbers and skill mix of staff were not appropriate to the assessed needs of all the residents, 26(2)**
b) **Not all health care professionals had up-to-date, mandatory training in Basic Life Support, fire safety, Therapeutic Management of Violence and Aggression or equivalent and Children First and, as such, did not have access to education to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).**

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in July 2016. 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.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

The policy and procedures did not address the following:

- The way in which entries in residents' records were made, corrected and overwritten.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the 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. Not all clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: Residents' records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured from loss or destruction, tampering, and unauthorised access or use.

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, in this case a combination of photograph,

wristband, and date of birth. Resident records were developed and maintained in a logical sequence and they were accessible to authorised staff only.

Records were written legibly and contained factual, consistent, and accurate entries. Generally, records were written in black indelible ink, with one entry in blue ink. A number of entries did not record the time using the 24-hour clock. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: An annual audit had not 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: The operating policies and procedures of the approved centre were developed by clinical and management staff with input from 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 all 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 monitoring pillar.

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in March 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the management of complaints. The policies were last reviewed in March 2017 and November 2017. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*. This included the process for managing complaints: 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 policies. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policies.

Monitoring: An audit of the complaints made through 'Your Service Your Say' had been completed as part of the wider service. There had been no audit of the minor complaints log held in the approved centre. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated individual with responsibility for dealing with complaints, who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. 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. All complaints were documented and dealt with by the nominated complaints officer or directly by staff receiving the complaint.

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 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

The policy did not address the following:

- The person with overall responsibility for risk management.
- The responsibilities of the Multi-Disciplinary Team.
- A defined quality and safety oversight and review structure as part of the governance process for risk management.
- Organisational risks.
- Capacity risks relating to the number of residents in the approved centre.
- Risk to the resident group during the provision of general care and services.
- Risks to individual residents during the provision of general care and services.

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The risk management policy had been implemented throughout the approved centre. Responsibilities were allocated at management level to ensure the effective implementation of risk management. Persons with responsibility for risk were known by staff in the approved centre. The position of risk advisor had become vacant just prior to the inspection. Risk management procedures actively sought to reduce identified risks to the lowest practicable level of risk. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register. There was an active ligature committee that was representative of the wider service. Ligature points had been identified within the approved centre and were being appropriately mitigated.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, and in conjunction with medication requirements or administration. Medical and nursing staff 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.

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 in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. The approved centre had an emergency plan that incorporated fire evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently in the new entrance foyer.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

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

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

INSPECTION FINDINGS

The clinical files of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was a documented assessment of capacity for the patient.

A Form 17: Treatment without Consent, Administration of Medicine for More than 3 Months – Involuntary Patient (Adult) had been completed within the required three-month time frame, and was in the clinical file. The Form 17 contained the following information:

- The names of the medication prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of the discussion with the patient in terms of the nature, purpose, and effects of the medication.
- Any views expressed by the patient.
- Supports provided to the patient in relation to the discussion and their decision-making process.

- Authorisation by a second consultant psychiatrist.

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

11.0 Inspection Findings – Codes of Practice

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

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

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

Admission, Transfer and Discharge

COMPLIANT

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 September 2017 addressed all of the required policy-related criteria for this code of practice. These included a procedure for involuntary admission and protocols for planned admission with reference to pre-admission assessment, eligibility for admission and referral letters. There was a policy on privacy, confidentiality and consent.

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

Discharge: The discharge policy, which was last reviewed in September 2017 included procedure for discharge of involuntary patients, a protocol for discharging homeless people and procedures for managing discharge against medical advice.

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

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

Evidence of Implementation:

Admission: One clinical file was inspected in relation to admission. The approved centre had a key worker system in place and the entire multi-disciplinary team record was contained in one set of documentation. The decision to admit was made by the Registered Medical Practitioner (RMP) or consultant psychiatrist. The resident was assessed on admission, and details of all assessments including a full physical examination 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 the discharge had been coordinated by the key worker. The community mental health team/primary care team were informed of the discharge within three days, and a comprehensive discharge summary was sent within 14 days. The discharge summary included details of the diagnosis.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan

Report reference: Page 31

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. Appropriate goals, treatment and resources were not specified in all the ICPs.	New	Corrective Action(s): ICP training for Nursing and medical staff took place in July 2018 and will be repeated for all staff in December 2018 to address educational needs of staff for ICP process. In addition the role of Co-ordinator of each MDT will be clearly identified, to ensure appropriate; goals, treatments and resources are in place to address service user needs. Post-Holder(s) responsible: ECD and ADON	Ongoing ICP training for all staff involved in ICP's. Ongoing development of a co-ordinator role to ensure governance of MDT meetings.	Achievable Co-ordinator role to be established	First training session in July 2018 December 2018
		Preventative Action(s): ICP Audits on a quarterly basis. Post-Holder(s) responsible:CNM3	Quarterly Audits	Achievable	Audit completed 09/09/2018
2. Not all the ICPs had been developed and reviewed with input from the wider MDT.	New	Corrective Action(s): Only medical and nursing staff available at present. The full MDT team will be invited to attend the Tuesdays MDT. Post-Holder(s) responsible: Heads of Discipline	To be discussed at the next catchment team meeting.	Achievable	September 2018
		Preventative Action(s): All available disciplines to attend MDT meeting. Post-Holder(s) responsible: Heads of Discipline	Included in ICP audit	Achievable	September 2018

Regulation 16: Therapeutic Services and programmes

Report reference: page 32

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. The range of therapeutic services and programmes provided was limited and did not ensure the restoration and maintenance of optimal levels of physical functioning of all residents, 16 (2).	New	Corrective Action(s): 1. General Practitioner post was filled and commenced in July 2018. GP attends the unit on a daily basis. 2. The OT Manager acknowledges the need for OT input from a Mental Health OT service. The OT Manager has requested for a Senior Occupational Therapist Maryborough Centre specific post to be put in place using development funding. The OT Manager has again submitted this request for this coming year's development funding. The OT post in POLL is a post dedicated to the clients at significant risk in the community, does not have capacity to cover the Maryborough Unit and is at the incorrect grade for working within this Approved Centre. In addition, this OT post in POLL will shortly be vacated Both of these new professional specialist posts will ensure on going assessment of service users physical capabilities to engage in tailored therapeutic activities. Post-Holder(s) responsible: OT Manager and ECD	GP already in post Request for Senior OT post for the Maryborough Centre to be approved under development funding.	None Staffing and funding issue	 December 2018
		Preventative Action(s): The therapeutic needs of residents will be assessed as above and an evaluation of same audited. Post-Holder(s) responsible: ADON	Assessment of therapeutic needs of residents will be audited.	Achievable	December 2018

Regulation 26: Staffing

Report reference: Pages 43 & 44

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. The numbers and skill mix of staff were not appropriate to the assessed needs of all the residents, 26 (2).	Reoccurring	Corrective Action(s): General Practitioner post was filled and commenced in July 2018 to attend the unit on a daily basis. The MDT team from POLL will be requested to attend the Maryborough Centre. Post-Holder(s) responsible: Heads of Discipline	Heads of Discipline to monitor attendance and review available resources.	Achievable	December 2018
		Preventative Action(s): MDT will attend appropriate to the needs of the residents Post-Holder(s) responsible: Heads of Discipline	Heads of Discipline to monitor attendance	Achievable	December 2018
5. Not all Health care professionals had up-to-date, mandatory training in Basic life support, fire safety, Therapeutic Management of Violence and aggression or equivalent and Children First and, as such did not have access to education to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).	Reoccurring	Corrective Action(s): Training dates to be posted/ emailed again to all Heads of Discipline as reminders for staff to complete training. Post-Holder(s) responsible: Heads of Discipline	Staff training numbers to be reviewed at Laois Offaly staff training meeting in Oct	Achievable	October 2108
		Preventative Action(s): Training to become a standing agenda item on all departmental meetings and senior catchment team meeting. Post-Holder(s) responsible: Heads of Discipline	Agenda item on all weekly staff meetings in Maryborough and POLL Team meeting.	Achievable	November 2018