Adult Mental Health Unit, Mayo University Hospital

ID Number: AC0001

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
- Acute Adult Mental Health Care
- Continuing Mental Health Care/Long Stay
- Psychiatry of Later Life
- Mental Health Rehabilitation
- Mental Health Care for People with Intellectual Disability

Most Recent Registration Date: 1 March 2017

Conditions Attached: None

Registered Proprietor: HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services, Community Healthcare West

Inspection Team:
- Karen McCrohan, Lead Inspector
- Martin McMenamin
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Inspection Date: 14 – 17 May 2019
Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 11 – 14 September 2018

Date of Publication: Thursday 28 November 2019

2019 COMPLIANCE RATINGS

<table>
<thead>
<tr>
<th>Regulations</th>
<th>Rules and Part 4 of the Mental Health</th>
<th>Codes of Practice</th>
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<tr>
<td>Compliant</td>
<td>Compliant</td>
<td>Compliant</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Non-compliant</td>
<td>Non-compliant</td>
</tr>
<tr>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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 2017 – 2019
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Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The Adult Mental Health Unit (AMHU) was located on the ground floor of Mayo University Hospital. The unit consisted of a main ward, which accommodated 28 residents at full capacity, and a four-bedded High Dependency Unit (HDU). There were nine multi-disciplinary teams (MDTs) which admitted to the approved centre: five General Adult teams, two Psychiatry of Old Age teams, one Rehabilitation and Recovery team, and one Mental Health Intellectual Disability team.

There has been an overall improvement in compliance with regulations, rules and codes of practice over the past three years: 74% compliance in 2017, 61% compliance in 2018 and 77% compliance in 2019. Twelve compliances with regulations were rated excellent.

Conditions to registration

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

Safety in the approved centre

- Food safety standards were complied with and kitchen areas were clean.
- Ordering, storage and administration of medication was implemented in a safe manner.

However:

- Not all health care professionals had up-to-date training in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act and Children First.
- Two medication prescription and administration records (MPARs) did not record any allergies or sensitives to any medication, including if the resident had no allergies. Five MPARs did not record the stop date and signature of the prescriber for each discontinued medication.
- While hazards were minimised, not all ligature points had been minimised to the lowest practicable level, based on risk assessment.

Appropriate care and treatment of residents

- The approved centre had developed and facilitated a new therapeutic programme, with input from various members of the MDT. The therapeutic programme provided by the approved centre was
evidence-based and met the assessed needs of the residents. The approved centre had acquired two new dedicated occupational therapists since the last inspection. Residents with previous admissions had noted improvements within the unit such as the new recreational and therapeutic programmes.

- Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, at a minimum of every six months.
- Each resident had an individual care plan (ICP). The ICP was discussed, agreed and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

However:

- ICPs remained non-compliant and this was identified as a high risk during the inspection. This was despite on-going efforts by the service to reform the ICP process through the facilitation of ICP training and the development of a new ICP booklet, which was in final draft. Although ICPs were developed by the MDT following a comprehensive assessment within seven days of admission, some presented as lacking detail. The ICP was not used to record the identified resident’s needs or the appropriate goals for two residents. Care and treatment required to meet the goals identified were not specified for two other residents, including the frequency and responsibilities for implementing the care and treatment. Two ICPs did not identify the resources required to provide the care and treatment identified.
- There was no documentary evidence that one resident received a full physical examination on admission to the approved centre.
- The following health check examinations were not consistently completed and documented in the clinical files of residents who had been in the approved centre for six months or more:
  - Residents’ blood pressure was not recorded in one case.
  - Residents’ smoking status was documented in three cases.
  - Residents’ Body Mass Index (BMI), waist circumference and body weight was not documented in three cases.
  - Residents’ nutritional status was not documented in three cases.
  - Medication review (as per prescriber guidelines) was not consistently completed and documented.
  - Residents’ dental checks were not consistently completed and documented.
  - Residents on anti-psychotic medication did not consistently receive a documented annual assessment of their glucose regulation.
  - In one of the four files examined, the resident’s fasting glucose level was documented as raised, with no apparent follow-up to this finding.
  - Residents’ blood lipids were not documented in three cases.
  - Residents’ prolactin levels were not measured and documented in all four clinical files inspected.

Respect for residents’ privacy, dignity and autonomy

- When a search was carried out, the resident was informed by those implementing the search of what was happening during a search and why. The search was implemented with due regard to the resident’s dignity, privacy and gender.
- Residents wore clothing that respected their privacy and dignity.
- There were clear signs in prominent positions where CCTV cameras were located in the approved centre. A resident was monitored solely for ensuring his/her health, safety, and welfare. The cameras were incapable of recording or storing a resident’s image in any format, and they transmitted images to a monitor that was viewed solely by the health professional responsible for the resident.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Where residents shared a room, the bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information.
- At the time of the inspection, the en suites in three of the bedrooms in the HDU were being renovated. This had been appropriately assessed prior to implementation for possible impact on current residents and staff. The process was managed well and no issues were noted at the time of the inspection.
- The approved centre was compliant with the Rules Governing the Use of Seclusion and the Code of Practice on Physical Restraint.

However:

- The approved centre was not kept in a good state of repair externally and internally. Ceiling tiles were stained in two storage rooms. An outdoor exercise bike in the courtyard was rusty. The key code on the door of the ladies’ toilet was broken for an extended period of time. Many of the reported issues, such as carpentry, electrical, and plumbing work, had a recorded status of ‘still in progress’.
- The approved centre was not clean in all areas. The storage room was dirty and both gardens were littered with cigarette ends.
- Not all clinical files inspected were maintained in good order; three of the five clinical files inspected contained loose pages. Radiology and blood printouts and medical correspondence were not properly secured in the three clinical files. A number of clinical files were in an illogical sequence, and were not securely attached within the white hardback folders. A number of clinical files were large in size and weight, resulting in overfilled poly pockets being torn. These deficits constituted a risk to confidentiality of residents’ clinical information.

**Responsiveness to residents’ needs**

- Residents were offered a variety of wholesome and nutritious food, and there was a choice of daily hot meals.
- The approved centre provided access to recreational activities on weekdays and during the weekend; however, during the resident interviews some of the residents reported that activities were more
limited at the weekend. Activities included access to TV, books, DVDs, games, music, and daily newspapers. Residents had access to a music group during the weekends. Opportunities were available for indoor and outdoor exercise and physical activity.

- Visiting times were reasonable and there were private visiting areas available.
- Information was provided in written form about the approved centre and residents’ diagnoses and medication.
- All complaints were handled promptly, appropriately and sensitively. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy; however, a minor complaints log was maintained.

**Governance of the approved centre**

- The approved centre was part of Community Healthcare West, formerly known as Community Healthcare Organisation (CHO) 2, and was governed under the Mayo Mental Health Services. This governance processes encompassed two core monthly meetings: the Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee meeting. The minutes evidenced discussions on key issues such as: risk management; quality initiatives; complaints and compliments; policies, procedures, protocols and guidelines; regulatory compliance; resource requirements; and performance monitoring. There was also a local Acute Unit Clinical Management Group, which met monthly, to discuss operational issues such as regulatory compliance, quality initiatives, monitoring and risk management. Additional working groups and committees, such as the Health and Safety Committee, Multi-Disciplinary Therapeutics working group, Judgement Support Framework working group and the Children First Implementation group, reported into this forum.
- Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Staff shortages, staffing structures, non-compliance with mandatory training, individual care plans, premises and inappropriate placements were identified as the main operational risks.
- Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns occurring in the service.
- The Approved Centre’s policies were developed by a multi-disciplinary steering Policies, Procedures, Protocols and Guidelines (PPPG) group in consultation with staff, with input for the Judgement Support Framework working group. All of the required operating policies and procedures were reviewed within the required three-year period.
- The approved centre had developed and implemented a good auditing schedule and monitoring was evident across all of the inspected regulations, rules and codes of practice.
- Heads of Discipline outlined regular engagement with staff and clear lines of responsibility.
- Resource deficits were noted across most disciplines, with significant shortages noted in psychology. Despite on-going efforts in the area of mandatory training, not all staff had up-to-date training on Basic Life Support, fire safety, management of violence and aggression, the Mental Health Act 2001 and Children First.
The following quality initiatives were identified on this inspection:

1. Establishment of a wide range of working groups and committees to facilitate regulatory compliance and to enhance the residents’ experience within the approved centre. For example:
   - Judgement Support Framework working group
   - Seclusion reduction group
   - Multi-disciplinary therapeutic group
   - Smoking cessation group
   - Discharge sub-group
   - Patient information group

2. Implementation of a new multi-disciplinary therapeutic programme. This included a walking group, gym exercises group, art group and music group. Additional sessions were facilitated such as ‘Preparation and support for attending your multi-disciplinary review’ and ‘Knowing my medicines’.

3. Development of new documentation to facilitate ongoing monitoring. This included a new search, sudden death and transfer systematic review form.

4. Establishment of two new dedicated occupational therapy posts within the approved centre.

5. Completion of upgrades to the premises, which included new furniture in the quiet room. The High Dependency Unit (HDU) en suites were being renovated at the time of the inspection.

6. Engagement of staff in non-mandatory further education courses and training. For example, four staff members were trained as Therapeutic Management of Violence (TMV) instructors.

7. Development of an information folder and a daily newsletter to aid the provision of information to residents.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adult Mental Health Unit (AMHU) was located on the ground floor of Mayo University Hospital. The unit was clearly signposted and accessible from the main hospital lobby. The doors to the approved centre were locked; entry to the unit was by requested access or swipe card. The unit consisted of a main ward, which accommodated 28 residents at full capacity, and a four-bedded High Dependency Unit (HDU).

The residents within the main ward were accommodated within six dormitories and two single bedrooms. The main ward included a reception area, quiet room, sitting room, dining room, laundry room, two activity rooms and occupational therapy room. The electroconvulsive therapy (ECT) suite was also located within the main ward. The HDU comprised of four single bedrooms, a large multi-functional room and the seclusion facility. Both the main ward and the HDU had access to two separate courtyards.

The unit had nine multi-disciplinary teams (MDTs) as an in-reaching model of care was used. The nine MDTs consisted of five General Adult teams, two Psychiatry of Old Age teams, one Rehabilitation and Recovery team, and one Mental Health Intellectual Disability team.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
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<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>32</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>27</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>13</td>
</tr>
<tr>
<td><strong>Number of wards of court</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Number of patients on Section 26 leave for more than 2 weeks</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was part of Community Healthcare West, formerly known as Community Healthcare Organisation (CHO) 2, and was governed under the Mayo Mental Health Services. There were four approved centres within the Mayo Mental Health service. The approved centre’s registered proprietor nominee was Mayo Mental Health Service’s General Manager. Mayo Mental Health Service’s governance processes encompassed two core monthly meetings: the Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee meeting. Both meetings were scheduled monthly and the meeting minutes were provided to the inspection team. The minutes evidenced discussions on key issues such as: risk management; quality initiatives; complaints and compliments; policies, procedures, protocols, and guidelines; regulatory compliance; resource requirements; and performance monitoring. Governance was further enhanced by a local Acute Unit Clinical Management Group, which met monthly, to discuss...
operational issues such as regulatory compliance, quality initiatives, monitoring and risk management. Additional working groups and committees, such as the Health and Safety Committee, Multi-Disciplinary Therapeutics working group, Judgement Support Framework working group and the Children First Implementation group, reported into this forum.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. Resource deficits were noted across most disciplines, with significant shortages noted in psychology. Despite on-going efforts in the area of mandatory training, not all staff had up-to-date training on Basic Life Support, fire safety, management of violence and aggression, the Mental Health Act 2001 and Children First.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. MDTs were involved in the development, implementation, and review of individual risk management processes. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns occurring in the service.

The Approved Centre’s policies were developed by a multi-disciplinary steering Policies, Procedures, Protocols and Guidelines (PPPG) group in consultation with staff, with input for the Judgement Support Framework working group. All of the required operating policies and procedures were reviewed within the required three-year period. The approved centre had developed and implemented a good auditing schedule and monitoring was evident across all of the inspected regulations, rules and codes of practice.

Twelve areas were rated as excellent on this inspection. The inspection also highlighted improvements from the previous year as non-compliances were down from fourteen to eight. Two of the improvements included the establishment of two new dedicated occupational therapy posts within the approved centre and the development of a new therapeutic and recreational activities programme. Individual care plans (ICPs) remained non-compliant and this was identified as a high risk during the inspection. This was despite on-going efforts, by the service, to reform the ICP process through the facilitation of ICP training and the development of a new ICP booklet, which was in final draft. Other areas requiring improvement included general health, medications, premises, staffing, maintenance of records, and the admission and discharge documentation.

The Mental Health Commission’s Governance Questionnaire was issued to the approved centre’s Heads of Discipline in advance of the inspection. Seven completed questionnaires were returned by the Executive Clinical Director, Occupational Therapy Manager, Principal Social Worker, Principal Psychologist, Business Manager, Area Director of Nursing and the Assistant Director of Nursing. These Heads of Discipline outlined regular engagement with staff and clear lines of responsibility. Visits from the heads of disciplines to the approved centre ranged from daily to occasional visits. Staff shortages, staffing structures, non-compliance with mandatory training, individual care plans, premises and inappropriate placements were identified as the main operational risks within the submitted questionnaires.
3.3 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.
4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X Moderate</td>
<td>X Critical</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X Critical</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X Low</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
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<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
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<tr>
<td>Regulation 6: Food Safety</td>
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<tr>
<td>Regulation 7: Clothing</td>
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<td>Regulation 8: Residents’ Personal Property and Possessions</td>
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<td>Regulation 9: Recreational Activities</td>
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<tr>
<td>Regulation 10: Religion</td>
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<tr>
<td>Regulation 14: Care of the Dying</td>
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<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
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<tr>
<td>Regulation 18: Transfer of Residents</td>
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<tr>
<td>Regulation 25: The Use of Closed Circuit Television</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
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<tr>
<td>Regulation 30: Mental Health Tribunals</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As no involuntary patient had received ECT since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

The inspection team met with eight residents during the inspection. The residents were complimentary of the care and treatment provided. The food and the facilities provided were described positively by all of the residents. Residents with previous admissions had noted improvements within the unit such as the new recreational and therapeutic programmes; however, residents reported that activities were more limited at the weekend. Resource deficits, such as nursing and psychology staff, were also acknowledged by residents.

A report compiled by the Irish Advocacy Network was provided to the inspection team. The report outlined several positive aspects of the service. Overall, most residents were reported to have been happy with their stay in the unit. Residents were reported to have been happy with the food, activities and their interactions with the nursing staff. The report also outlined areas in need of improvement; this included a request for more talking therapies. Additionally, concerns were raised regarding the lack of meaningful activities at the weekend and the lack of internet access within the unit. The length of time taken to address maintenance issues also identified as a problem by some the residents.
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:

- General Manager/Registered Proprietor Nominee
- Executive Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker
- Principal Psychologist Nominee
- Assistant Director of Nursing
- Consultants x 4
- Senior Clinical Pharmacist
- Clinical Pharmacist
- Nurse Practice Development Co-ordinator
- Regulatory Compliance Advisor
- Clinical Nurse Manager III
- Clinical Nurse Manager II x3
- Non-Consultant Hospital Doctor
- Section Officer

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. Any relevant information provided to the inspection team at the feedback meeting was included within the report.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: A minimum of two person-specific resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The identifiers were appropriate to the residents’ communication abilities. Where residents had cognitive deficits, wristbands were used. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate alerts were used to inform staff of the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre’s menus were approved monthly by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs.

Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. There was a choice of daily hot meals. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly. Easy to access safe and fresh drinking water was available to residents at all times.

Nutritional and dietary needs were assessed by the multi-disciplinary team, where necessary, and addressed in residents’ individual care plans. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Any special nutritional requirements were not regularly reviewed by a dietitian. However, referrals could be made to a dietitian as required through the main hospital. Intake and output charts were maintained for residents, where appropriate.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in January 2019. 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 were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene commensurate with their role. Staff training was documented, and evidence of certification was available.

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage and serving of food. Food was prepared in the main kitchen of the hospital and was transported to the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. 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 rated excellent because the approved centre met all criteria of the Judgement Support Framework.

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy on residents’ clothing. 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. A record of residents wearing nightclothes during the day, as indicated by their individual care plan, was maintained and monitored.

Evidence of Implementation: Residents changed out of nightclothes during daytime hours unless specified otherwise in their Individual Care Plan (ICP). Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. 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

(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 policy in relation to residents’ personal property and possessions, which was last reviewed in November 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre’s policy.

Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions. However, residents were encouraged to leave valuables and large amounts of money at home. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in January 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. However, during the resident interviews some of the residents reported that activities were more limited at the weekend. Accessible and suitable information on the activities was available to residents through a recreation programme list.

Activities included access to TV, books, DVDs, games, music, and daily newspapers. Residents had access to a music group during the weekends. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity.

Communal areas were suitable for recreational activities. The approved centre had a quiet room, a large sitting room with TV, and a separate supervised TV room was available. Activities were developed, maintained, and implemented with resident involvement, and residents provided input or feedback during weekly resident community meetings or an individual basis. Records of resident attendance at recreational activities were documented in individual clinical files.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 10: Religion

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre. There was an oratory available within the grounds of the main hospital to support residents’ religious practices. Residents had access to multi-faith chaplains, if required. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. Residents were facilitated in observing or abstaining from religious practice in line with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in May 2017. The policy included the requirements of the Judgement Support Framework with the exception of the required visitor identification methods.

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

Monitoring: Restrictions on residents’ rights to receive visitors was monitored and reviewed on an ongoing basis. Analysis was completed to identify opportunities to improve visiting processes.

Evidence of Implementation: There were no visiting restrictions implemented for any resident at the time of the inspection. Appropriate and reasonable visiting times were publicly displayed in the approved centre. While there was not a designated visitors’ room, a separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting area available was suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents could use mail, fax, and telephone if they wished. The internet including Wi-Fi access was not available to residents. This was raised as an issue by residents in the Irish Advocacy Network’s report on the approved centre, which was provided to the inspection team. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in November 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had been completed to identify opportunities for improvement of search processes.

Evidence Of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file for one resident who was searched was inspected. Risk had been assessed prior to the search of the resident. The resident’s verbal consent to the search was documented within the clinical file. However, there was no documentary written evidence to show that consent was sought, as the resident’s signature to the consent was not documented. No routine environmental searches had taken place since the last inspection.
The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

The search was implemented with due regard to the resident’s dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

A written record of every search of a resident, and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who attended for the search.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The care of the dying policy was last reviewed in September 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: No resident had required end of life care in the approved centre since the last inspection. However, a systems analysis had been undertaken following the sudden death of a resident who had been transferred to the main hospital for care and treatment. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The sudden death of a resident, which occurred after the resident was transferred to the general hospital for care and treatment, was reviewed. This death was reported to the Mental Health Commission within the required 48-hour timeframe. The needs of the resident’s family, next-of-kin, and friends were accommodated. Support was given to other residents and staff following a resident’s death.

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 15: Individual Care Plan

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

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

INSPECTION FINDINGS

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

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

Monitoring: Residents’ ICPs were audited on a monthly basis since the beginning of the year with a sample spread across all teams to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process, which included further ICP training, wider audit approaches, and a new ICP template that included previously identified gaps.

Evidence of Implementation: Ten ICPs were reviewed on inspection. Residents were initially assessed at admission and an ICP was completed by the admitting clinician. Whilst the immediate needs of the residents were identified, these were in some cases addressed within the clinical notes rather than in the ICPs. Although ICPs were developed by the MDT following a comprehensive assessment within seven days of admission, some presented as lacking detail. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Evidence based assessments were used where possible.

The ICP was not used to record the identified resident’s needs or the appropriate goals for two residents. It also did not specify the care and treatment required to meet the goals identified for two other residents, including the frequency and responsibilities for implementing the care and treatment. Two ICPs did not identify the resources required to provide the care and treatment identified.

Where ICPs did not include these process elements, there was evidence within clinical notes corresponding to each resident’s needs and goals, and confirmation that appropriate care and treatment was being provided. Nine of the ICPs included an individual risk management plan; one did not. Six ICPs did not detail a discharge plan for the resident.

The ICP was updated following review, as indicated by the resident’s changing needs, condition, circumstances, and goals. Residents had access to their ICP and were kept informed of any changes following review by their keyworker or member of the MDT.

The approved centre was non-compliant with this regulation for the following reasons:
a) The ICP was not used to record appropriate goals for two residents.
b) The ICP did not specify the care and treatment required to meet the goals identified for two residents.
c) Two ICPs did not identify the resources required to provide the care and treatment identified.
Regulation 16: Therapeutic Services and Programmes

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<th>Regulation 16: Therapeutic Services and Programmes</th>
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<td>(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.</td>
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<td>(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.</td>
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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 November 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

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

Evidence of Implementation: The approved centre had developed and facilitated a new therapeutic programme, with input from various members of the multi-disciplinary team. The therapeutic programme provided by the approved centre was evidence-based and met the assessed needs of the residents, as documented in the residents’ individual care plans. A visually attractive list of therapeutic services and programmes provided within the approved centre was available to residents in poster format. Residents were also given a daily newsletter as a reminder of the programmes available. All therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Adequate resources and facilities were available. The approved centre had acquired two new dedicated occupational therapists since the last inspection. Therapeutic services and programmes were provided in separate dedicated rooms, and each ward had facilities to carry out group programmes or one to one therapy sessions. This included the occupational therapy office, activities room, and external training facilities. Additional therapeutic services and programmes required were provided in external training centres when necessary. For example, the approved centre engaged with the Football Association of Ireland (FAI) to facilitate residents’ access to the Kickstart programme. A record was maintained of residents’ participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 for medical care was inspected. The resident was transferred to a medical unit within Mayo University Hospital. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident’s care and treatment plan, including needs and risks, and the resident’s accompaniment requirements on transfer. The resident was risk assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident’s needs.

The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, and the resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents’ 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

(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 in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in December 2017. The medical emergencies policy was last reviewed in June 2017. The policies combined included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the 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 not recorded and not monitored. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED) machine at all times. The AED machine and the emergency trolley were checked on a daily basis. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate healthcare interventions in line with their individual care plan. Residents general health needs were monitored and assessed as indicated by the residents’ specific needs, at a minimum of every six months.

The clinical files of four residents, who had been cared for in the approved centre for six months or more, were inspected. These general health assessments included a physical examination and documented family history. The following health check examinations were not consistently completed and documented:

- Residents’ blood pressure was not recorded in one case.
- Residents’ smoking status was documented in three cases.
- Residents’ Body Mass Index, (BMI), waist circumference and body weight was documented in three cases.
- Residents’ nutritional status was not documented in three cases.
- Medication review (as per prescriber guidelines) was not consistently completed and documented.
- Residents’ dental checks were not consistently completed and documented.

The four residents on anti-psychotic medication had received an electrocardiogram (ECG) assessment of their heart function and this was documented. Residents on anti-psychotic medication did not consistently receive a documented annual assessment of their glucose regulation. In one of the four files examined, the resident’s fasting glucose level was documented as raised, with no apparent follow-up to this finding. Residents’ blood lipids were not documented in three cases. Resident’s prolactin levels were not measured and documented in all four clinical files inspected.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general health checks and associated results. Residents had access to national screening programmes according to age and gender including breast check, cervical screening, retina check - for diabetics only, and bowel screening. Information was not provided to residents regarding the national screening programmes available through the approved centre. Residents had access to a smoking cessation programme.

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

a) The six-monthly general health assessment was inadequately completed in four cases as there was no documentary evidence of blood pressure, BMI, weight, waist circumference, smoking status, nutritional status, medication review and dental check, 19, (1)(b).

b) All four residents on antipsychotic medication did not receive a systematic assessment, which included fasting glucose, blood lipids, and prolactin levels, 19, (1)(b).
(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 operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in November 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** Residents were provided with a service-user booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, relevant advocacy and voluntary agencies details. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Visiting times and visiting arrangements were displayed throughout the approved centre, but these were not specified in the information booklet. Residents were not provided with details of residents’ rights. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident’s diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents’ needs. The content of medication information sheets included information on indications for use of all medications to be administered to...
the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had an operational policy in relation to resident privacy, which was last reviewed in November 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

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

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were respectful in their interactions with residents. Staff were discreet when discussing residents’ condition or treatment needs. Residents wore clothing that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

Rooms were not overlooked by public areas. Bedrooms in the High Dependency Unit were overlooked from the garden area, and it was possible for other residents and members of the public to see into the bedrooms from the garden area. Previously, the bedroom windows had opaque film on the lower panes of the glass, but staff reported that residents had pulled it off. However, the bedroom windows were fitted with curtains, which could be closed to protect residents’ privacy.

Where residents shared a room, the bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

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 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

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

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

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Accommodation for each resident in the approved centre assured their comfort and privacy. All bedrooms were appropriately sized to match residents’ needs. Sufficient indoor and outdoor spaces were provided for residents to move about.

There were adequate and suitable furnishings. The approved centre provided appropriately sized communal rooms. The premises was adequately lit, heated, and ventilated. Heating could not be safely controlled in the resident’s own room. While hazards were minimised, not all ligature points had been minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in a good state of repair externally and internally. Ceiling tiles were stained in two storage rooms. The door connecting the yard to the approved centre, where supplies came in, had a broken hinge. However, this was reported to have occurred on the first day of the inspection. An outdoor exercise bike in the courtyard was rusty. The key code on the door of the ladies’ toilet was broken for an extended period of time. However, this had been rectified on the final day of the inspection.
A programme of routine maintenance of the premises was not implemented. The PMAC system, an electronic reporting system, was used to log faults and maintenance issues. Many of the reported issues, such as carpentry, electrical, and plumbing work, had a recorded status of ‘still in progress’. At the time of the inspection, there was no process in place to address routine issues such as replacing bulbs or fixing blocked toilets. However, a programme of renewal of the fabric and decoration of the premises was developed and implemented and records of such programme were maintained. Contractors had been assigned to complete larger projects such as painting, replacing floors, replacing furniture, and replacing and repairing extractor fans.

The approved centre was not clean as a locked storage room was dusty and both gardens were littered with cigarette ends. Remote or isolated areas of the approved centre were monitored.

Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to implementation for possible impact on current residents and staff. At the time of the inspection, the en suites in three of the bedrooms in the Higher Dependency Unit were being renovated. The bedrooms and en suites were closed to residents during the day while work was underway. At 5 pm, the bedrooms were opened to residents; however, en suites remained locked. Throughout the day and night, these three residents could use another bathroom and toilet until work was complete. This process was managed well and no issues were noted at the time of the inspection.

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

a) The gardens and storeroom were not clean and the premises was not maintained in good order as reported issues of maintenance were outstanding, 22 (1)(a).

b) A programme of routine maintenance was not implemented as there was no process in place to address routine issues such as replacing bulbs or fixing blocked toilets at the time of the inspection., 22 (1)(c).

c) Ligature points had not been minimised, 22 (3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in March 2019. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All nursing, pharmacy, and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

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: Each resident had an MPAR, ten of which were inspected. Each MPAR included two resident identifiers, records of all medications administered and details of medication dosage, route and frequency.

Five MPARs did not record the stop date and signature of the prescriber for each discontinued medication. Two MPARs did not record any allergies or sensitives to any medication, including if the resident had no allergies. These issues were corrected during the inspection.

Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the resident’s care or condition. This was documented in the clinical file. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration, and expired medications were not administered. All medicines were administered by a registered nurse or registered medical practitioner, and any advice provided by the resident’s pharmacist regarding the appropriate use of the product was adhered to.

The medication trolley and medication cupboard remained locked at all times and secured in a locked room. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Refrigerators used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. An inventory of medications was conducted on a weekly basis by the pharmacy technician, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication. Medications that were no longer required, which were past their expiry date, or had been...
dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

a) Two MPARs did not contain a record of any allergies or sensitives to any medication, including if the resident had no allergies, 23 (1).

b) Five MPARs did not record the stop date and signature of the prescriber for each discontinued medication, 23 (1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in February 2019. The policy addressed all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the health and safety 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

(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: There was a clear written operational policy dated February 2019 in place in relation to the use of closed circuit television (CCTV). The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff could articulate the processes on the use of CCTV, as set out in the policy.

Monitoring: The CCTV equipment was checked regularly to ensure it was operating appropriately. This was documented. Analysis was completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located in the approved centre. A resident was monitored solely for ensuring his/her health, safety, and welfare.

The Mental Health Commission had been informed about the approved centre’s use of CCTV. The cameras were incapable of recording or storing a resident’s image in any format, and they transmitted images to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff. The policy was last reviewed in February 2019, and it included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: There was an organisational chart to identify leadership structures and the lines of authority and accountability of the approved centre staff. A planned and actual staff rota showing the staff on duty at any one time during the day and night was maintained in the approved centre. Staff were recruited in accordance with the approved centre’s policy and procedures for recruitment, selection and appointment.

At the time of the inspection, psychology deficits were reported within the Sector 4, Psychiatry of Old Age North and Rehabilitation and Recovery teams. The Mental Health Intellectual Disability team had no occupational therapy resource. However, the approved centre had two dedicated occupational therapists. One consultant was due to leave the service and no locum cover was available at the time of the inspection. The numbers of nursing staff were sufficient to meet resident needs.

There was an appropriately qualified staff member on duty at all times. The approved centre had a staffing plan in place, which addressed the skill mix of staff within the approved centre, the assessed needs of the residents, the layout of the approved centre and the level of acuity of psychiatric illness. The required number of staff on night duty was sufficient to ensure the safety of residents in the event of a fire or other emergency.
Annual staff training plans were completed for staff in order to identify required training and skills development. Orientation and induction training was completed for staff. Not all health care professionals had up to date training in fire safety, Basic Life Support, Management of violence and aggression, the Mental Health Act and Children First, as set out in the table below:

### Staff mandatory training details

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic life support</th>
<th>Fire Safety</th>
<th>Management of violence and aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (31)</td>
<td>24</td>
<td>17</td>
<td>22</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>Consultant Psychiatrist (10)</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Medical (21)</td>
<td>16</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Occupational Therapist (7)</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Social Worker (12)</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Psychologist (7)</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Staff were not trained in line with the assessed needs of the resident group profile and of individual residents. A number of staff were trained in manual handling, care of residents with an intellectual disability, residents’ rights, and recovery-centred approaches to mental health care and treatment. Staff had also completed training in infection control and prevention, risk management, incident reporting, and the protection of children and vulnerable adults. All staff training was documented.

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

The following is a table of staff assigned to the approved centre.
<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Mental Health Unit</td>
<td>CNM 3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM 2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>MTA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NCHD</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Senior Pharmacist</td>
<td>0.5 WTE</td>
<td>0</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Multi Task Attendant (MTA), Non-Consultant Hospital Doctor (NCHD).

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

a) Not all healthcare professionals were up-to-date in mandatory training, which included fire safety, Basic Life Support, management of violence and aggression and Children First, 26 (4).

b) Not all healthcare professionals had completed mandatory Mental Health Act 2001 training, 26(5).
(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in January 2019. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff were trained in best-practice record keeping.

Monitoring: All resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process, insofar as was practicable. Analysis was completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: Residents’ records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use. Five clinical files were inspected. Resident records were reflective of the residents’ status at the time of inspection and the care and treatment being provided. Not all clinical files inspected were maintained in good order; three of the five clinical files inspected contained loose pages. Radiology and blood printouts and medical correspondence were not properly secured in the three clinical files. A number of clinical files were in an illogical sequence, and were not securely attached within the white hardback folders. A number of clinical files were large in size and weight, resulting in overfilled poly pockets being torn.

Resident records were physically stored together. Resident records were maintained using an identifier, which was unique to the resident. Only authorised staff made entries in residents’ records, or specific sections therein. Hand-written records were legible, written in black indelible ink, and were readable when photocopied. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was non-compliant with this regulation because records were not maintained in a manner to ensure completeness and ease of retrieval. Three clinical files contained loose pages, and a number of clinical files were not developed and maintained in a logical sequence, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented up-to-date register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service-users, as appropriate. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year timeframe, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Where generic policies were used, the approved centre had a written statement to this effect adopting the generic policy, which was reviewed at least every three years.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in January 2018. 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 for patients and their legal representatives. Adequate resources were present to support the Mental Health Tribunal process. Staff accompanied and assisted patients to attend their Mental Health Tribunal and provided assistance, as necessary.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in November 2018. The policy and procedures addressed the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed on the noticeboard, and it was detailed within the service-user’s information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made through noticeboards and information booklets. Complaints could be lodged verbally, in writing, by telephone, and through complaint, feedback, or suggestion forms.

All complaints were handled promptly, appropriately and sensitively. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints, apart from minor complaints, were dealt with by the nominated person - the complaints officer. There was a process for
addressing minor complaints within the approved centre. Minor complaints were documented. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process made available to them.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan. The complainant’s satisfaction or dissatisfaction with the investigation findings was not documented.

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 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in March 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the
lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and seclusion, electro-convulsive therapy, and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. Not all of the nine multi-disciplinary teams maintained a record of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated 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 training and education and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 69: The Use of Seclusion

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The seclusion policy was last reviewed in February 2019. The policy included all of the relevant guidance criteria of this rule pursuant to Section 69 of the Mental Health Act 2001, including who may implement seclusion, the provision of information to the resident, and ways of reducing seclusion use.

Training and Education: The approved centre maintained a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings, which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical files. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

Clinical files of three residents who had been in seclusion on at least one occasion each since the last were inspected. The approved centre complied with the code of practice on the use of seclusion across all three episodes.

In all episodes, seclusion was only implemented in the resident’s best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

Each resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. Each resident was informed of the ending of seclusion on all occasions.
All episodes of seclusion were recorded in each resident’s clinical file and all uses of seclusion were recorded in the seclusion register. A copy of the seclusion register was in place within the resident’s clinical file and available to inspectors.

The approved centre was compliant with this rule.
9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

56. - In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where—
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either—
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent—
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

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

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either—
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

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

INSPECTION FINDINGS

The inspection team examined the clinical file of one detained patient who was identified as being in continuous receipt of medication for a period in excess of three months. The patient’s ability to consent to receive continued treatment was assessed by the consultant psychiatrist. The result of the assessment was that the patient lacked capacity to consent. This was documented.

A Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been appropriately completed. It included details of the discussion with the patient on the nature and purpose and the effects of the medication. Any views expressed by the patient were recorded. Authorisation was provided by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Use of Physical Restraint

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

**INSPECTION FINDINGS**

**Processes:** There was a written policy in place dated August 2018 in relation to the use of physical restraint. The policy was reviewed annually. The policy included all of the guidance criteria of this code of practice.

**Training and Education:** The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy.

**Monitoring:** The approved centre forwarded the relevant annual report to the Mental Health Commission.

**Evidence of Implementation:** The clinical files of two residents, which included a total of three episodes of physical restraint, were inspected. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident’s unsafe behaviour. In all cases, the restraint order lasted for less than five minutes.

Cultural awareness and gender sensitivity was demonstrated in all three episodes of physical restraint. In each case examined, residents’ next of kin were not informed about the physical restraint. However, the associated reasons were documented in the clinical file. Each of the two residents was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. The resident was given the opportunity to discuss the episode with members of MDT as soon as was practicable.

The approved centre was compliant with this code of practice.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. All elements of the policy complied with the code of practice. The policy was reviewed annually, and it was last reviewed in September 2018.

The protocols in place included:
- How and where the initial and subsequent doses of Dantrolene was stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hypothermia.

Training and Education: All staff involved in ECT were trained in line with international best practice. All staff involved in ECT had appropriate training, including Basic Life Support techniques.

Evidence of Implementation: One voluntary resident had received ECT since the last inspection. Their clinical file was inspected. The resident’s capacity to consent was assessed and documented prior to obtaining their consent on receiving ECT treatment. The consultant psychiatrist gave the resident appropriate information on ECT, to enable the resident to make a decision on consent. The resident was provided with all the required information specified in section 4.1 of this code of practice. An interpreter was available if necessary to explain ECT. Information was provided on the likely adverse effects of ECT, including risk of cognitive impairment and amnesia. The resident’s consent was documented in relation to each episode of ECT treatment.

The approved centre had a dedicated ECT suite, a private waiting room, an adequately equipped treatment room, and a recovery room. There was a facility to monitor EEG on two channels and the machines were regularly maintained. This was documented. The material and equipment, including emergency drugs, were in line with best international practice.

There were up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia, which were prominently displayed. There was a named consultant psychiatrist who had overall responsibility for ECT, and a named consultant anaesthetist who had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The resident’s clinical status, and cognitive status was assessed before and after each ECT programme and were detailed in the resident’s clinical file after each treatment. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was compliant with this code of practice.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in February 2019, the transfer policy was last reviewed in June 2017, and the discharge process policy was last reviewed in August 2018. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. There was no documentary evidence that the resident’s family member/carer/advocate were involved in the admission process, with the resident’s consent. The resident received an admission assessment, which included the presenting problem, past psychiatric history current and historic medication, current mental state, a risk assessment, and assessment of social and housing circumstances. The resident’s family history and medical history was not assessed and documented. There was no documentary evidence that the resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan did not address the early warning signs of relapse and risk. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident’s family. A pre-discharge assessment was completed, which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

A preliminary discharge summary was not sent to the resident’s general practitioner/primary care/community mental health team within three days of discharge. A comprehensive discharge summary was issued. However, this documentation was not dated. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up. Risk issues, such as signs of relapse, were not addressed in the discharge summary.
The approved centre was not compliant with this code of practice for the following reasons:

a) On admission to the approved centre, the resident’s family history and medical history was not assessed and documented. The resident did not receive a full physical examination, 15.3.
b) The discharge plan did not address early warning signs of relapse and risk, 34.2.
c) A preliminary discharge summary was not sent to the general practitioner/primary care/community mental health team within three days of discharge, 38.3.
d) The comprehensive discharge summary was issued to relevant personnel without a documented date, 38.3 (b).
e) Risk issues, such as signs of relapse, were not addressed in the discharge summary, 38.4.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 15: Individual Care Plan

**Reason ID : 10000390**

The ICP was not used to record appropriate goals for two residents. The ICP did not specify the care and treatment required to meet the goals identified for two residents. Two ICPs did not identify the resources required to provide the care and treatment identified.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2019 new ICP document implemented. Training from external expert attended by staff. On-going training available from practice development.</td>
<td>Quarterly ICP audits</td>
<td>Achievable</td>
<td>01/07/2019</td>
<td>Executive Clinical Director and treating consultant</td>
</tr>
</tbody>
</table>

| Preventative Action | Evaluation of sessions by residents | Yes | 14/10/2019 | Executive Clinical Director, Occupational therapist manager & practice development |

Education/information sessions to be provided to residents on ICPs - commencing Oct 2019. The HSE plans to standardise ICP nationally and AMHU are requesting to be involved as a pilot site. NCHD's are informed as part of their induction and ICP's are discussed at Professional Practice Development Group meeting with Consultant and NCHD's.
## Regulation 19: General Health

### Reason ID : 10000380

The six-monthly general health assessment was inadequately completed in four cases as there was no documentary evidence of blood pressure, BMI, weight, waist circumference, smoking status, nutritional status, medication review and dental check, 19, (1)(b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A new 6 monthly physical health assessment form had being developed incorporating all the regulatory requirement and HSE physical health assessment form. All 6 monthly general health assessments for residents now completed and monitored by Liaison NCHD.</td>
<td>Audit within 3 months - Jan 2020.</td>
<td>Achievable</td>
<td>02/10/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Six monthly general health assessments delegated to Liaison NCHD. Increase frequency of general health auditing to six monthly. Aug 2019 - Mayo Mental Health Service has established a MDT Physical Health Working group which plans to introduce the HSE Making Every Contact Count (MECC) assessment form and provide training/education to staff.</td>
<td>6 monthly audit of Reg 19. Training records &amp; evaluations maintained</td>
<td>Achievable</td>
<td>31/10/2019</td>
</tr>
</tbody>
</table>

### Reason ID : 10000381

All four residents on antipsychotic medication did not receive a systematic assessment, which included fasting glucose, blood lipids, and prolactin levels, 19, (1)(b).

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<tr>
<th>Specific</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>July 2019 - A new assessment booklet was introduced to include all regulatory requirements &amp; ensures a comprehensive physical health assessment including bio-chemistry and medication reconciliation is completed.</td>
<td>6 monthly audit of regulation 19 - next due Jan 2020</td>
<td>Achievable</td>
<td>01/10/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Medications are reviewed weekly at the MDT by the treating team. Six monthly audit</td>
<td>6 monthly audit</td>
<td>Achievable</td>
<td>06/01/2020</td>
</tr>
</tbody>
</table>
## Regulation 22: Premises

**Reason ID: 10000382**

The gardens and storeroom were not clean and the premises was not maintained in good order as reported issues of maintenance were outstanding, 22 (1)(a).

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<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The Garden is cleaned daily by maintenance. Garden and courtyard area swept and bins emptied on daily bases. Storeroom added to the routine cleaning schedule and will form part of the monthly cleaning audit carried out staff, contract cleaners and Infection Prevention Control Nurse (IPCN). All maintenance issues reported through the PMAC system. Agreement in place that requests are reviewed by the maintenance manager or the foreman within 2-4 hour. Emergency issues will be dealt with first, normally within a 12 hour period. All other maintenance issues to be dealt with within 5 working days.</td>
<td>Monthly cleaning audits Review Schedule of maintenance 3 monthly and re-audit of Regulation 22 annually (due Feb 2020).</td>
<td>Achievable but cleaning of the garden limited to once daily. Barrier - current industrial relations issues with maintenance department within MUH, who have overall responsible for maintenance issues in AMHU.</td>
<td>02/10/2019</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Added as agenda item to AMHU management monthly meetings for ongoing review. Escalated onto Area Management Team Risk Register for monthly reviews. Monthly cleaning audits conducted by CNS IPCN and the manager of ISIS (contract cleaners). Review Schedule of maintenance 3 monthly and re-audit of Regulation 22 annually (due Feb 2020). | Monthly cleaning audits Review Schedule of maintenance 3 monthly and re-audit of Regulation 22 annually (due Feb 2020). | Achievable but cleaning of the garden limited to once daily. Barrier - current industrial relations issues with maintenance department within MUH, who have overall responsible for maintenance issues in AMHU. | 23/10/2019 | Maintenance manager, Business manager, ADON. |
**Reason ID : 10000383**

A programme of routine maintenance was not implemented as there was no process in place to address routine issues such as replacing bulbs or fixing blocked toilets at the time of the inspection., 22 (1)(c).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual premises audit reviewed and update by ADON, Maintenance manager, Business manager and ANM3, with agreed routine programme of maintenance including specific action plan identified to address routine maintenance in the unit as identified in the report - every 3 months or sooner if required.</td>
<td>Review Schedule of maintenance 3 monthly and re-audit of Regulation 22 annually (due Feb 2020).</td>
<td>Barrier - current industrial relations issues with maintenance department within MUH, who have overall responsible for maintenance issues in AMHU.</td>
<td>04/10/2019</td>
<td>Maintenance manager, Business manager, Area Director of Nursing and ADON.</td>
</tr>
</tbody>
</table>

| Preventative Action | Agreement in place that requests are reviewed by the maintenance manager or the foreman within 2-4 hour. Emergency issues will be dealt with first, normally within a 12 hour period. All other maintenance issues to be dealt with within 5 working days. Added as agenda item to AMHU management monthly meetings for on-going review. Escalated onto Area Management Team Risk Register for monthly reviews. | Review Schedule of maintenance 3 monthly and re-audit of Regulation 22 annually (due Feb 2020). | Barrier - current industrial relations issues with maintenance department within MUH, who have overall responsible for maintenance issues in AMHU. | 04/10/2019 | Maintenance manager, Business manager, ADON. |

**Reason ID : 10000384**

Ligature points had not been minimised, 22 (3).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ligature audit completed July 2019 and ligatures minimised to the lowest possible level with controls in place. Program of eliminating ligatures continue. New furnishing are ligature free.</td>
<td>Annual ligature audit - July 2020</td>
<td>Achievable - with controls in place</td>
<td>24/07/2020</td>
<td>ADON</td>
</tr>
</tbody>
</table>

<p>| Preventative Action | All new refurbishment and equipment will be ligature free. | Annual ligature audit - July 2020 | Achievable | 24/07/2020 | ADON and CNM3 |</p>
<table>
<thead>
<tr>
<th>Reason ID : 10000385</th>
<th>Two MPARs did not contain a record of any allergies or sensitives to any medication, including if the resident had no allergies, 23 (1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The 2 MPARs were immediately reviewed by a doctor to complete the allergy status. All other MPARs were checked by the pharmacist and found to be complete. The same doctor was responsible for the 2 MPARs in question; was new to the service and had not completed induction training with the pharmacist; induction was completed the following day. Nursing staff were reminded not to administer medication if the allergy status is incomplete on the MPAR.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Achievable</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>Quarterly MPAR Audits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>All prescribers will complete induction prior to commencing work. An induction booklet for prescribers will be developed to highlight importance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable</td>
<td>Achievable</td>
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</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000386</th>
<th>Five MPARs did not record the stop date and signature of the prescriber for each discontinued medication, 23 (1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The MPARs were reviewed and corrected by the prescriber</td>
</tr>
<tr>
<td>Measurable</td>
<td>Achievable</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>Quarterly MPAR Audits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Sub-group of Drugs &amp; Therapeutics group to review MPARs and develop new as only regular section contains prompt for signature &amp; date of discontinuation, as current MPARs do not have a prompt for signature and date of prescriber on discontinuation of medication in the PRN or depot section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Reason ID : 10000387**

Not all healthcare professionals were up-to-date in mandatory training, which included fire safety, Basic Life Support, management of violence and aggression and Children First, 26 (4). Not all healthcare professionals had completed mandatory Mental Health Act 2001 training, 26(5).

<table>
<thead>
<tr>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A new Autumn 2019 training schedule has being developed incorporating all mandatory training. This includes a one day programme which covers BLS, Manual Handling Practical, Risk Management and Hand Hygiene. Four new trainers are now providing Therapeutic Management of Violence and Aggression (TMVA) training 3 times a month. Staff facilitated and prompted to complete On-line training to be completed by all staff.</td>
<td>3 monthly audit of training records by each head of discipline</td>
<td>Achievable - staff access to training and time allocated to attend training.</td>
<td>02/10/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>3 monthly audit of mandatory training records by each head of discipline. Staff facilitated to attend/complete all mandatory training. On-going schedule of training provided to staff.</td>
<td>Audit of training records 3 monthly</td>
<td>Achievable</td>
<td>29/05/2020</td>
</tr>
</tbody>
</table>
### Regulation 27: Maintenance of Records

**Reason ID**: 10000393

Records were not maintained in a manner to ensure completeness and ease of retrieval. Three clinical files contained loose pages, and a number of clinical files were not developed and maintained in a logical sequence, 27(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New admission clinical files introduced to all new admissions. Clinical files down sided after a specified length of time.</td>
<td>New admission clinical files introduced to all new admissions. Clinical files down sided after a specified length of time.</td>
<td>Audit of Regulation 27 due May 2020</td>
<td>Achievable</td>
<td>07/10/2019</td>
<td>Executive Clinical Director, Business Manager CNM3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly monitoring of records by administration staff.</td>
<td>Weekly monitoring of records by administration staff.</td>
<td>Executive Clinical Director, Business Manager CNM3</td>
<td>Achievable</td>
<td>14/10/2019</td>
<td>Executive Clinical Director, Business Manager CNM3</td>
</tr>
</tbody>
</table>
### Code of Practice on Admission, Transfer and Discharge to and from an approved centre

**Reason ID : 10000375**

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission to the approved centre, the resident’s family history and medical history was not assessed and documented. The resident did not receive a full physical examination, 15.3.</td>
<td>Audit of Code of practice on admission and Reg 19 General health.</td>
<td>Achievable</td>
<td>01/07/2019</td>
<td>Dr Skerritt Executive Clinical Director</td>
</tr>
</tbody>
</table>

#### Corrective Action

**Specific**: July 2019 new Admission assessment booklet was introduced including physical assessment, family history and medical history.

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**Preventative Action**

**Specific**: An annual audit of clinical files under the Code of Practice will be completed. Code of practice discussed at Professional Practice Development Group meeting with Consultant and NCHD’s

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**Reason ID : 10000376**

<table>
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<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The discharge plan did not address early warning signs of relapse and risk, 34.2.</td>
<td>Audit</td>
<td>Achievable</td>
<td>01/07/2019</td>
<td>Executive Clinical Director</td>
</tr>
</tbody>
</table>

#### Corrective Action

**Specific**: The new ICP doc introduced in July 2019 includes a discharge care plan summary sheet which including early warning signs of relapse and risk. This form is now completed, copied and forwarded to the community team/GP on discharge.

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**Preventative Action**

**Specific**: An annual audit of the discharge summary will be completed. Code of practice discussed at Professional Practice Development Group meeting with Consultant and NCHD’s

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**Reason ID : 10000377**

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A preliminary discharge summary was not sent to the general practitioner/primary care/community mental health team within three days of discharge, 38.3. The comprehensive discharge summary was issued to relevant personnel without a documented date, 38.3 (b). Risk issues, such as signs of relapse, were not addressed in the discharge summary, 38.4</td>
<td>Audit</td>
<td>Achievable</td>
<td>31/01/2020</td>
<td>Executive Clinical Director</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>A new one page discharge summary is completed and forwarded to the GP/Community team on day of discharge (or next working day). A full discharge letter is prepared by the NCHD, signed by Consultant and forwarded to G.P. within two weeks of patient's discharge.</td>
<td>Audit of discharges</td>
<td>Achievable</td>
<td>01/07/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>An audit of the residents discharge is completed. NCHD's are informed as part of their induction and Code of practice discussed at Professional Practice Development Group meeting with Consultant and NCHD's</td>
<td>Audit</td>
<td>Achievable</td>
<td>31/01/2019</td>
</tr>
</tbody>
</table>
Appendix 2: Background 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.