Acute Psychiatric Unit, Ennis Hospital

ID Number: AC0022

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Psychiatric Unit, Ennis Hospital
Ennis
Co. Clare

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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Inspection Date:
14 – 17 May 2019

Previous Inspection Date:
4 – 7 December 2018

Inspection Type:
Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Monday 14 October 2019

2019 COMPLIANCE RATINGS

REGULATIONS

8
1
22

Compliant
Non-compliant
Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH

2

Compliant
Non-compliant
Not applicable

CODES OF PRACTICE

1

Compliant
Non-compliant
Not applicable
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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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services
Dr Susan Finnerty

In brief

The approved centre was a 39-bed unit, located in Ennis General Hospital. It provided acute in-patient mental health care to residents of North Tipperary and the county of Clare, a total catchment area of approximately 220,000 people. It included a Psychiatry of Old Age unit with five beds.

Eight teams admitted residents into the approved centre. These teams were fully staffed with the exception of the West Sector which had a vacant consultant psychiatrist post.

There was an improvement in compliance with regulations, rules and codes of practice. In 2018, compliance was 66%; in 2019, compliance was 74%. Eight compliances with regulation were rated excellent, an improvement from four in 2018.

Conditions to registration

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

Condition 1: To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 1 in that progress updates were provided to the Mental Health Commission. The approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Condition 2: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 2 in that progress updates were provided to the Mental Health Commission. The approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.
Safety in the approved centre

- Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations and hygiene was maintained to support food safety requirements.
- Not all staff were trained in fire safety, Basic Life Support, Management of Violence and Aggression or the Mental Health Act (2001). Not all nursing staff were trained in Children First.
- Staff were trained in manual handling, infection control and prevention, care of residents with an intellectual disability, and risk management. Staff had also completed training in incident reporting. Staff were not trained in dementia care, end of life rights, resident rights, and recovery-centred approaches to mental health care and treatment.
- Ligature points in the approved centre had been minimised to the lowest practicable level.
- Individual risk assessments were completed prior to episodes of physical restraint and seclusion and at resident admission. Individual risk assessments were not completed at resident transfer.
- There was evidence that medication management was carried out in a safe manner.

However:

- Not all staff were trained in fire safety, Basic Life Support, Management of Violence and Aggression or the Mental Health Act (2001). Not all nursing staff were trained in Children First.
- A detailed risk assessment was not included within the ICPs.

Appropriate care and treatment of residents

- Ten individual care plans (ICPs) were examined and all ICPs were developed within seven days of admission. Resident involvement in the ICP process was documented and each resident was offered a copy of their ICP. All ICPs were reviewed on a weekly basis and a key worker was identified to ensure continuity in the implementation of the ICP. Where appropriate the ICP contained a discharge plan.
- Therapeutic services and programmes provided by the approved centre were evidence-based, reflective of good practice guidelines and met the assessed needs of the residents, as documented in the residents’ ICPs. Therapeutic services and programmes included a health promotion group, Irish Therapy dogs, Wellness and Recovery Action Plan (WRAP) group, mindfulness groups, a relaxation group, and a medication concordance group. There was also a therapeutic activity facilitated by the occupational therapist two days per week. The approved centre had an art room, an activation kitchen, and a group therapy room.

However:

- Six-monthly general health assessments were inadequately completed in a number of cases. Family and personal history, Body Mass Index, weight, waist circumference, nutritional status, and dental checks were not completed and documented.
- In three of the ten ICPs inspected, resident goals were not appropriately identified; instead, unspecific goals such as ‘optimise mental health’ were documented. In three cases, the care and treatment required to meet the resident goals was not appropriately documented. In two of the ten
ICPs examined, the person or discipline responsible for providing the care and treatment was not identified within the ICP.

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

- The approved centre was kept in a good state of repair externally and internally and was clean, hygienic and free from offensive odours. There was a cleaning schedule implemented in the approved centre.
- Where a resident shared a room, the bed screening ensured that their privacy was not compromised. All other windows could be obscured by blinds if required.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make and receive private phone calls through an available portable phone and were free to use mobile phones.
- No resident was subject to visiting restrictions at the time of the inspection. Appropriate and reasonable visiting times were publicly displayed in the approved centre and a separate visiting area was provided where residents could meet visitors in private.
- Any searches of residents or their property were implemented with due regard to the resident’s gender, dignity and privacy. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.
- There were clear signs in prominent positions where CCTV cameras were located. The cameras were incapable of recording or storing a resident’s image in any format, and they did not transmit images other than to a monitor that was viewed solely by staff in the nursing office.
- The use of seclusion and physical restraint were compliant with the relevant rules and code of practice.

However:

- There was one shower in the High Dependency Unit (HDU) which had four beds. Residents could only access this shower by walking through another person’s bedroom, and only if the resident in this bedroom agreed to it. Otherwise, residents in the HDU unit were escorted to the main unit to use the showers there.
- Three bedrooms in the HDU did not have blinds or opaque glass on the windows, which potentially compromised the privacy of HDU residents. Blinds were also missing from the observation window on the seclusion room door.
- The lighting throughout the approved centre was not sufficiently bright.

**Responsiveness to residents’ needs**

- Residents received a nutritious diet with a choice of food at meal times that was attractively presented.
- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities and facilities included TV, DVDs, books, including a library in the art room, art materials, and exercise equipment. Group activities included crafts, a games group, board games, cards, gardening, group outings to various locations, music, and
creative writing. Individual activities undertaken with residents included outings, sports, and swimming.

- Written information was provided to residents about the approved centre, their diagnosis and medication.
- There was an excellent complaints procedure in place.

However:

- Residents’ personal property and possessions were not safeguarded when the approved centre assumed responsibility for it. The property room contained several bags and boxes of residents’ property with no labels on them, so the property owner was not identifiable. The safe for valuables was untidy and contained many items that did not have resident identifiers on them, including a gift card, a purse, and an iPod. It was unclear whether this particular safe was for lost property or for storing valuables belonging to current residents.

- Resident money was kept in individual envelopes in a safe. In three cases, the balance counted in the envelope tallied with the amount documented in the ledger. In one case, there was a discrepancy in terms of the amount of funds. This was rectified immediately by the responsible staff. On admission, the approved centre did not consistently compile detailed property checklists with each resident of their personal property and possessions.

**Governance of the approved centre**

- The approved centre had an established structure of governance in place and the organisation chart illustrated the lines of responsibility and reporting.

- The Acute Unit meeting was responsible for operational matters in the approved centre, including over-capacity, staff training, the risk register, the implementation of the HSE smoking ban and findings from the 2018 Mental Health Commission inspection report.

- A strong culture of risk management was evident within the approved centre with senior management actively working to manage risks presenting within the unit specifically in relation to the potential for occupancy over the registered capacity. The Quality and Safety Committee reviewed escalated risk issues including those highlighted by the system of auditing, feedback on the service’s development of national standards, and the review of risk registers and risks escalating from the incident reporting process. The Serious Incident Management Team were responsible for reviewing serious incidents escalated to their group and communicating any learning that emerged from these reviews. All disciplines reported having received training in risk management.

- Service user engagement played a major role in terms of the governance of the approved centre and the service user engagement representative provided input to the approved centre at senior management level.

- Staff supervision and appraisal existed in each of the departments, although these were not formalised for the nursing staff. Staff were trained in manual handling, infection control and prevention, care of residents with an intellectual disability, incident reporting and risk management.

However:
• Not all staff were trained in mandatory requirements, with medical staff and consultant psychiatrists training in particular need of attention. Staff were not trained in dementia care, end of life rights and resident rights. They had been trained in Recovery Principles.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A ‘Seclusion Care Plan’ had been developed by the nursing team within the approved centre. This care plan ensured that the practices required under the Rule on Seclusion were adhered to at all times when a resident was nursed in the seclusion room.

2. A ‘Student Welcome Pack’ had been put together in order to ensure that all aspects of the staff orientation process had been completed for students once they commenced their placements within the approved centre.

3. A bi-annual ‘Mental Health Service Newsletter’ was launched in the Spring. This newsletter contained details of the quality initiatives undertaken within the approved centre such as the ‘Safewards’ initiative.

4. New flooring had been installed into the Psychiatry of Later Life unit. The design of this flooring was ‘dementia friendly’ in order to reduce the risk of residents falling.

5. Implementation of the ‘Safewards’ initiative, involving ten interventions over a five year period to foster positive staff-patient relationships and reduce conflict on the ward.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within Ennis General Hospital. It provided in-patient mental health care to residents of North Tipperary and the county of Clare, a total catchment area of approximately 220,000 people. The approved centre was built around its internal garden which contained a gazebo and several seats. It had a total of 39 beds; 4 of these were located in the High Dependency Area and the Psychiatry of Old Age unit had a total of 5 beds. The remaining beds were located in the general adult ward; four rooms had four beds, three rooms had three beds, there was one two-bedded room and three single rooms. The approved centre had a large recreational room, a library and multiple office spaces as well as three ‘alcoves’ used for resident relaxation. Two of these alcoves each contained a large fish tank. The approved centre had recently been repainted. The High Dependency unit contained a seclusion room. The approved centre had exceeded its registered bed-numbers on two occasions since the previous inspection.

In total eight teams admitted residents into the approved centre, the Thurles team, the Nenagh team, the Clare East Sector team, the Clare South Sector team, the North Clare Sector team, the Clare West Sector team, the Older Persons team, and the Rehabilitation team. These teams were fully staffed with the exception of the West Sector which had a vacant consultant psychiatrist post.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>39</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>37</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>9</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>7</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre had an established structure of governance in place and the organisation chart illustrated the lines of responsibility and reporting.

The Acute Psychiatric Unit (APU) Ennis had five main management groups in place. The Acute Unit Meeting was responsible for discussing operational matters that arose on the APU. These included the concerns arising from potential over-capacity within the approved centre, updates on staff training, topics emerging from the risk register, the implementation of the HSE Smoking ban as well as findings from the 2018 Mental Health Commission report. The Executive Management Team met fortnightly and discussed operational management issues such as those arising from local management team meetings and the potential changes...
The approved centre was also represented on some regional committees such as the Policy Procedure and Protocol Group and the Drugs and Therapeutics Committee. A strong culture of risk management was evident within the approved centre with senior management actively working to manage risks presenting within the unit specifically in relation to the potential for occupancy over the registered capacity.

Representatives from nursing, medical, occupational therapy, psychology and social work departments provided feedback to the inspection team in terms of their respective teams. All disciplines reported having received training in risk management. A strong culture of staff supervision and appraisal existed in each of the departments, although these were not formalised for the nursing staff. Two Social Work staff were not supervised by the principal social worker, receiving supervision from the Executive Clinical Director instead. Staff shortages were highlighted as potential risks for each department. Service user engagement played a major role in terms of the governance of the approved centre and the service user engagement representative provided input to the approved centre at senior management level.

### 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>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8: Personal Property and Possessions</td>
<td>✓</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X Critical</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
<td>✓</td>
<td>X Low</td>
<td>X Low</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X Low</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X Moderate</td>
<td>X High</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 High</td>
<td>X Moderate</td>
<td>X Low</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:

| Regulation |
|--------------------------|-----------------------------|-----------------------------|-----------------------------|
| Regulation 4: Identification of Residents |
| Regulation 5: Food and Nutrition |
| Regulation 7: Clothing |
| Regulation 10: Religion |
| Regulation 11: Visits |
| Regulation 12: Communication |
| Regulation 30: Mental Health Tribunals |
| Regulation 31: Complaints Procedures |
### 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 had not admitted any children since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
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.

One resident had recently made two complaints within the approved centre and requested that we follow this up to ensure that the appropriate processes were being followed in regards to them. The complaints had been received by the Clinical Nurse Manager 3 (CNM3) who was following the investigative protocols for both. Several minor maintenance issues were reported by one resident and these were shown to the inspection team. While feedback about the food was generally positive, one resident highlighted the fact that although soup was consistently listed on the menu, it was not always served at teatime.

The Irish Advocacy Network representative had the following feedback:

- Residents were happy with the activities timetable and the activities co-ordinator.
- Residents would like to have a tea and coffee dispensing machine on the unit as it is difficult to get a cup of tea after 8pm.
- Residents did not like having to ‘sleep out’ in Cappahard Lodge when the approved centre was over its bed numbers.

Only one resident questionnaire was returned to the inspection team.
6.0 Feedback Meeting

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

- Registered Proprietor nominee
- Acting Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Mental Health Act Administrator
- Clinical Nurse Manager 2
- Acting Assistant Director of Nursing
- Executive Clinical Director
- Senior Clinical Psychologist
- Principal Social Worker
- Clinical Nurse Manager 3
- Director of Nursing

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.
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 June 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 the identification of residents, as set out in the policy.

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The approved centre used identity wristbands, name, and date of birth of each resident as identifiers. The preferred person-specific identifiers used were appropriate to the residents’ communication abilities, and were detailed within residents’ clinical files. The identifiers were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. A red sticker alert system was used to assist staff in recognising the difference between 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 March 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre’s menus were approved regularly by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Irish Food Pyramid. Residents had at least two choices for meals, which they could order through ward staff. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot drinks were provided to residents by request at any time of the day. A source of safe fresh and cold drinking water was available at all times in easily accessible locations in the approved centre.

For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary and addressed in residents’ individual care plans. An evidence-based nutrition assessment tool was used. Their special dietary needs were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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.

COMPLIANT
Quality Rating Excellent
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.

Processes: The approved centre did not have a policy in relation to food safety.

Training and Education: There was no policy in place for staff to read, sign or articulate. 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, preparation, cooking, and serving of food. Food was prepared in St. Joseph’s Hospital and was transported to the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection and appropriate hand washing areas was provided for catering services.

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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in 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 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 ICP, was kept and monitored.

Evidence of Implementation: One resident was prescribed to wear night clothes during the day, which was specified in their individual care plan. Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with gender-specific 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 operational policy in relation to residents’ personal property and possessions, which 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 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: Residents were supported to manage their own property unless this posed a danger to the resident, or others as indicated by their individual care plan. Residents’ personal property and possessions were not safeguarded when the approved centre assumed responsibility for it. The property room contained several bags and boxes of residents’ property with no labels on them, which meant the property owner was not identifiable.

Secure facilities were provided for the safe-keeping of the residents’ valuables, monies and personal possessions, including two safes. One safe was used to store money and the second safe was used to store valuables. The safe for valuables was untidy and contained many items that did not have resident identifiers on them, including a gift card, a purse, and an iPod. It was unclear whether this particular safe was for lost property or for storing valuables belonging to current residents.

The second safe was found to be in good order. Resident money was kept in individual envelopes. Four envelopes were reviewed in conjunction with the accounting ledger. In three of these cases, the balance counted in the envelope tallied with the amount documented in the ledger. In one case there was a discrepancy in terms of the amount of funds, however this was rectified immediately by the responsible staff. The access to and use of resident monies was overseen by two members of staff. On admission, the
approved centre did not consistently compile detailed property checklists with each resident of their personal property and possessions. Three clinical files inspected did not contain a checklist. A fourth file inspected was poorly documented, unsigned and not dated.

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

a) Records of residents’ money stored within secure facilities were not up to date, 8 (3).

b) Records of residents’ personal property were not documented within each residents’ personal file, 8 (3).

c) The registered proprietor did not ensure that provision was made for the safe keeping of all personal property and possessions. The property and possessions stored in the property rooms were not labelled, therefore the property owner was unidentifiable, 8 (6).
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 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. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities was distributed throughout the main unit, but there was no timetable or other communication of activities provided to the psychiatry of later life residents.

Activities and facilities included TV, DVD, books including a library in the Art Room, art materials, and exercise equipment. Group activities included crafts, a games group, board games, cards, gardening, group outings to various locations, music, and creative writing. Individual activities undertaken with residents included outings, sports, and swimming.

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre offered access to a gym including a rowing machine, recumbent exercise bike, cross trainer, treadmill, fussball table, pool table, and a boxing punch bag. Outdoors, and gardening groups took place on a seasonal basis. Outdoor walks took place.

Communal areas were suitable for recreational activities. The approved centre had an art room, an activation kitchen, and a group therapy room. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in group records or in the clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
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 March 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable, and there was a Church available on-site to support residents’ religious practices. A priest or Eucharistic minister attended the approved centre with communion on a Sunday. Residents had access to multi-faith chaplains, if required. They were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.
(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.
(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.
(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.
(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.
(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in June 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 visits, as set out in the policy.

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

Evidence of Implementation: No resident was subject to visiting restrictions at the time of the inspection. Appropriate and reasonable visiting times were publicly displayed in the approved centre. 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. This was communicated to all relevant individuals publicly through a sign displayed on the wall. The visiting area available was suitable for visiting children, with adequate space and toys and games for children to play with.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 12: Communication

(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 policy in relation to resident communication, which was last reviewed in May 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 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, mobile and landline telephones including the internet, if they wished. 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. No resident had communication examined by staff at the time of the inspection.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy did not address the process for communicating the approved centre’s search procedures to residents and staff.

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

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: 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 consent was sought and documented. 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 gender, dignity and privacy. Policy requirements were implemented when illicit substances were found as a result of a search. A written record of the search of the resident was available which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

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 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

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

As there had been no deaths in the approved centre since the last inspection, the approved centre was only assessed under the two pillars of processes and training and education for this regulation.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in June 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 individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents’ ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process; a new ICP template has been developed by the approved centre but not yet implemented at the time of the inspection.

Evidence of Implementation: Ten ICPs were examined in order to inspect this regulation. The ICP was contained in a composite set of documents with allocated space for goals, treatment, care and resources required. The ICP document included space for reviews and was not amalgamated with progress notes. Each resident was assessed on admission and an initial ICP was completed by the admitting clinician in order to address the immediate needs of the resident. All ICPs were developed within seven days of admission.

The ICPs included comprehensive assessments of the residents’ medical, psychiatric, and psychosocial history, their medication history, current medications, and a current physical health assessment. A detailed risk assessment was not included within the ICPs. Resident involvement in the ICP process was documented and each resident was offered a copy of their ICP. Where a resident declined to accept a copy of their ICP, this was documented.

In three of the ten ICPs inspected, resident goals were not appropriately identified; instead, unspecific goals such as ‘optimise mental health’ were documented. In three cases, the care and treatment required to meet the resident goals was not appropriately documented. In two of the ten ICPs examined, the person or discipline responsible to provide the care and treatment was not identified within the ICP. All ICPs were reviewed on a weekly basis and a key worker was identified to ensure continuity in the implementation of the ICP. Where appropriate the ICP contained a discharge plan.

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

a) For three of the ten ICPs reviewed, the ICP did not identify appropriate goals.
b) In three ICPs, the care and treatment was not identified.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in April 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 not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Therapeutic services and programmes provided by the approved centre were extensive, evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents. All therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Therapeutic services and programmes included a health promotion group, Irish Therapy dogs, Wellness and Recovery Action Plan (WRAP) group, mindfulness groups, a relaxation group, and a medication concordance group. A national support group called GROW facilitated a group once monthly. There was also a therapeutic activity facilitated by the occupational therapist once a week. There were plans for an increase in occupational therapy led groups; a week prior to this inspection, an occupational therapist had commenced in the approved centre two days per week.

Adequate resources and facilities were available. One team did not have a psychologist but this was being managed by other psychologists while the service was attempting to fill the vacant position. Therapeutic services and programmes were provided in separate dedicated rooms, and each ward had facilities to carry out group programmes or one to one sessions. All therapeutic services and programmes needed were provided internally. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in February 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 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 out of the approved centre was inspected. Communication records with the receiving facility were documented and available on inspection. Verbal communication and liaison took place between the approved centre and the receiving facility prior to the transfer. This included a discussion of the reason for the transfer and the residents’ accompaniment requirements on transfer. Discussions of the residents’ care and treatment plan were not included in communication records.

Documented consent of the resident to the transfer was available. There was no documented evidence to indicate that an assessment of the resident was completed prior to the transfer, including an individual risk assessment relating to the transfer and the resident’s needs.

Full and complete written information for the resident who was transferred was not provided to the receiving facility. While a resident transfer form was completed by the approved centre prior to the transfer, a letter of referral including a list of current medications was not sent. No checklist had been completed by the approved centre to ensure that comprehensive resident records had been sent during the transfer.

The approved centre was non-compliant with this regulation because full and complete information about for one resident was not provided to the receiving facility during the transfer. The approved centre did not send a letter of referral, the residents’ care and treatment plan, or a list of the resident’s current medications to the receiving facility on transfer, 18 (1).

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW
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 October 2018. The medical emergencies policy was last reviewed in September 2018. 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 recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED) machine at all times. The AED machine and the emergency trolley were not checked every week on a consistent basis. No medical emergency had taken place in the approved centre since the previous inspection.

Registered medical practitioners assessed resident 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 health needs were monitored and assessed as indicated by the residents’ specific needs, within six months.

The clinical files of five residents who had been cared for in the approved centre for six months or more were assessed. These assessments included a physical examination and documentation of residents’ blood pressure and smoking status. In two cases family or personal medical history were not completed or documented as part of the general health check. Three files failed to include residents’ Body Mass Index (BMI), waist circumference and body weight. Nutritional status was omitted in three of five files inspected and no medication review was documented in three cases. Finally, only one of the files inspected included a dental check for the resident.

The file of one resident who was in receipt of anti-psychotic medication in excess of six months was inspected. This resident received a documented annual assessment of their glucose regulation, blood lipid,
prolactin levels, and an electro-cardiogram assessment of heart function had been carried out for the resident as required.

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, retinal check, and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre. Residents had access to a smoking cessation programme, and nicotine patches were available to residents.

The approved centre was non-compliant with this regulation because the six-monthly general health assessment was inadequately completed in a number of cases. Family and personal history, BMI, weight, waist circumference, nutritional status, and dental check were not completed and documented in all cases, 19(1)(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in June 2018. The policy included requirements of the Judgement Support Framework with the exception of the methods for providing information to residents with specific communication needs.

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

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

Evidence of Implementation: Residents were provided with a service-user booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents’ rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. 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 processes pillar.
Regulation 21: Privacy

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

INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to resident privacy, which was last reviewed in 2019. 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 called by their preferred name in the approved centre and the general demeanour of staff was conducive to resident privacy and dignity. The manner in which staff addressed and communicated with residents was observed to be respectful at all times. Staff used discretion when discussing a resident’s condition or treatment needs and sought permission prior to entering a room as appropriate. All residents were wearing clothes that respected their privacy and dignity during the inspection.

All bathrooms, showers and toilets had locks on the inside of their doors unless there was an identified risk to the resident. Where a resident shared a room, the bed screening ensured that their privacy was not compromised. Three bedrooms in the High Dependency Unit (HDU) did not have blinds or opaque glass on the windows, which potentially compromised the privacy of HDU residents. Blinds were also missing from the observation window on the seclusion room door. All other windows could be obscured by blinds if required. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make and receive private phone calls, through an available portable phone.

The approved centre was non-compliant with this regulation because resident’s privacy and dignity was not appropriately respected at all times for the following reasons:

- a) The observation panel on the door to the seclusion room did not have blinds or curtains.
- b) Three windows in the High Dependency Unit (HDU) did not have blinds or curtains.
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 September 2018. 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: The main door of the APU unit was locked; access was managed via an electronic swipe card system whilst a receptionist controlled access to the unit for all other persons. The door to the psychiatry of later life unit was locked on the basis of results of residents’ risk assessments. Accommodation for each resident in the approved centre assured their comfort and privacy and met their assessed needs. 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. It was adequately heated, and ventilated. Hazards were minimised in the approved centre. The approved centre was kept in a good state of repair externally and internally. It was recently repainted and new flooring was installed in the Psychiatry of Later life Unit since the last inspection. The grass in the garden was overgrown. A new oven was installed in the occupational therapy kitchen since the last inspection, and it was clean.
The approved centre was clean, and hygienic and free from offensive odours. There was a cleaning schedule implemented in the approved centre. The remote or isolated areas of the approved centre were monitored.

Ligature points in the approved centre has been minimised to the lowest practicable level. The approved centre was not adequately lit. The lighting throughout the approved centre was not sufficiently bright and it was poor overall. Two of the bulbs in the psychiatry of later life unit were not working at the time of the inspection, and this was reported to maintenance. Heating could not be safely controlled in the president’s own room, in compliance with health and safety guidance and building regulations.

There was an adequate number of showers and toilets in the main unit and in the Psychiatry of Old age unit. There was one single shower in the HDU unit. Residents could only access this shower by walking through another person’s bedroom, and only if the resident in this bedroom agreed to it. Otherwise, residents in the HDU unit were escorted to the main unit to use the showers there.

One bathroom contained four trolleys, which meant the space in it was restrictive. Toilets were not easy to find and access. Toilets were not clearly marked. There were no signs on the toilets next to bedrooms. At the time of the inspection, the approved centre had ordered signs for all toilets, which were due to arrive. There was documented evidence of this.

Wheelchair accessible toilet facilities were present in the approved centre but were not identified on doors. The approved centre did not have a dedicated laundry room.

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

a) The premises was not adequately lit, 22 (1)(b).

b) There was an insufficient number of toilets and showers for residents in the High Dependency Unit, and this was not conducive to the wellbeing of residents 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 June 2016. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The process applied when medication is refused by the resident.
- The process for medication reconciliation.
- The process for reviewing resident medication.

Training and Education: All nursing, pharmacy, and medical staff had signed the signature log to indicate that they had read and understood the policies. 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 evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident’s MPAR. A record was kept when medication was refused by the resident.

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.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Medication refrigerators were kept locked. Refrigerators used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. Food and drink was not stored in areas used for the storage of medication.
A system of stock rotation was not implemented to avoid the accumulation of old stock. An inventory of medications was not conducted on a monthly basis by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date.

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 compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
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 March 2019. The policy addressed all 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 written operational policy dated March 2017 in place in regard to the use of closed circuit television (CCTV). The policy included all of the requirements of the Judgement Support Framework, with the exception of the maintenance of CCTV cameras by the approved centre.

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 quality of CCTV images was checked regularly to ensure the equipment 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. A resident was monitored solely for ensuring his or her health, safety, and welfare. The High Dependency Unit had CCTV.

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 did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. The monitors were in working order and were only viewed by staff in the nursing office.

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 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 adopted the Health Services Executive National Recruitment service policy as the basis of its staffing policy. There was a written statement in place indicating that this policy was in place within the approved centre.

The policy included the following requirements of the Judgement Support Framework:

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

The policy did not include the following:

- The job description requirements.
- Staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of the residents and the size and layout of the approved centre.
- The staff rota details and the methods applied for its communication to staff.
- The use of agency staff.
- The process for the reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff to another.
- The roles and responsibilities in relation to staff training.
- The ongoing staff training requirements and the frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE
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.

<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 (48)</td>
<td>42</td>
<td>22</td>
<td>45%</td>
<td>42</td>
<td>87.5%</td>
</tr>
<tr>
<td>Consultant Psychiatrist (9)</td>
<td>4</td>
<td>44%</td>
<td>3</td>
<td>33</td>
<td>11%</td>
</tr>
<tr>
<td>Medical (16)</td>
<td>11</td>
<td>68.75%</td>
<td>11</td>
<td>68.75</td>
<td>9</td>
</tr>
<tr>
<td>Occupational Therapist (7)</td>
<td>7</td>
<td>100%</td>
<td>7</td>
<td>100%</td>
<td>6</td>
</tr>
<tr>
<td>Social Worker (8)</td>
<td>7</td>
<td>87.5%</td>
<td>7</td>
<td>87.5%</td>
<td>4</td>
</tr>
<tr>
<td>Psychologist (7)</td>
<td>7</td>
<td>100%</td>
<td>7</td>
<td>100%</td>
<td>2</td>
</tr>
</tbody>
</table>

**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. The numbers and skill mix of staffing were sufficient to meet resident needs. Staff were recruited in accordance with the approved centre’s policy and procedures for recruitment, selection and appointment. All staff were vetted in accordance with the approved centre’s recruitment policy and staff had sufficient qualifications to do their jobs.

There was an appropriately qualified staff member on duty and in charge 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. Where agency staff were used, there was a comprehensive contract between the approved centre and the registered staffing agency.

Annual staff training plans were not completed for staff in order to identify required training and skills development. Orientation and induction training was completed for staff. Not all staff were trained in fire safety, Basic Life Support, Management of Violence and Aggression or the Mental Health Act (2001). Not all nursing staff were trained in Children First.

Staff were trained in manual handling, infection control and prevention, care of residents with an intellectual disability and risk management. Staff had also completed training in incident reporting. Staff were not trained in dementia care, end of life rights and resident rights. Staff were not trained in dementia care, end of life rights and resident rights. They had been trained in Recovery Principles.

All staff training was documented. Opportunities were made available to staff by the approved centre for further education. In-service training was completed by appropriately trained and competent individuals. 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>Main unit</td>
<td>CNM2</td>
<td>2</td>
<td>Shared</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Activation nurse (9pm-5pm)</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.5</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Referral</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Referral</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLL Unit</td>
<td>RPN</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Referral</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>Referral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

a) Not all healthcare professionals were up-to-date with training and education to enable them to provide care and treatment in accordance with best contemporary practice. Not all healthcare professionals were trained in fire safety, Basic Life Support or Therapeutic Management of Aggression and Violence, 26 (4).

b) The registered proprietor did not ensure that all healthcare professionals were made aware of the provisions of the Act and all regulations under the Act as not all healthcare professionals had completed training in the Mental Health Act (2001), 26 (5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in May 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. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use. 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; one clinical file inspected contained loose pages. Not all resident records were developed and maintained in a logical sequence, in one clinical file older admission details were confused with current admission details.

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, accuracy, and ease of retrieval. One clinical file contained loose pages, and one clinical file was not 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, electronic 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 used the HSE’s National Framework for policy development. It included the requirements of the *Judgement Support Framework* with the following exceptions:
- The roles and responsibilities in relation to the development, management, and review of operating policies and procedures.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The process for making obsolete and retaining previous versions of operating policies and procedures.

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

**Monitoring:** An annual audit had not been undertaken to determine compliance with review timeframes. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing the policy.

**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 to an extent, but the standardisation did not include the document owner and the date at which the policy would be effective from.

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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, monitoring, and evidence of implementation pillars.
Regulation 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 September 2017. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

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

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

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

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

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

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

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

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

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 May 2019. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. 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 for senior management to consider. Details of the analysis were considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence Of Implementation: There was a nominated 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, 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, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

There were 19 minor complaints, and 14 formal complaints lodged since the last inspection. 13 formal complaints were resolved and 1 complaint was under investigation at the time of the inspection. There were no complaints escalated since the previous inspection. All complaints were handled promptly, appropriately and sensitively. 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 were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. 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 separate from the resident’s individual care plan. The complainant’s satisfaction or dissatisfaction with the investigation findings was documented, where applicable.

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 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 April 2017. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for 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 staff were trained in organisational risk management. 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. Not all training was documented.

Monitoring: The risk register was not reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit did not measure actions taken to address risks identified against the timeframes identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, 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 practical level of risk. 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 and at resident admission. Individual risk assessments were not completed at resident transfer. Structural risks, including ligature points, remained but were effectively mitigated.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. 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. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

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, monitoring 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 reception area of the hospital.

The approved centre was compliant with this regulation.
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 September 2018. The policy included all of the relevant guidance criteria of this rule pursuant to Section 69 of the Mental Health Act 2001.

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.

The clinical files of three residents who had been in seclusion on one occasion each was inspected. The approved centre complied fully with the code of practice on the use of seclusion across the 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 agree 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 September 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 files of three residents who had been physically restrained 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 episodes of physical restraint. In each case examined, residents’ next of kin were informed about the physical restraint. Each of the three 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 the MDT as soon as was practicable.

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:

Admission: The admission policy was dated February 2018 and set out the protocols for residents’ planned admissions, pre-admission assessments, and referral letters. The policy met all of the code of practice policy guidance criteria.

Transfer: There was a policy on transfer dated February 2018. It met all of the code of practice policy guidance criteria. The transfer policy set out the roles and responsibilities of staff in the transfer of residents and included procedures for involuntary transfers.

Discharge: The discharge policy was dated February 2018. The policy included the procedure for discharge of involuntary patients, the protocol for discharging homeless people and the procedure for managing discharge against medical advice.

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

Monitoring: An audit of the implementation of and adherence to the admission, transfer, and discharge policies occurred.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. The admission assessment was comprehensive. All assessments and examinations were documented within the clinical file, and the resident was assigned a key worker. The resident’s family member/carer/advocate were involved in the admission process with the resident’s consent.

Transfer: The approved centre’s transfer process was non-compliant with Regulation 18: Transfer of Residents.

Discharge: The file of one resident who were discharged was inspected. The discharge plan was in place as part of the individual care plan (ICP). It did not include the estimated date of discharge. It did include documented communication with primary care, and a follow-up plan. Early warning signs of relapse and risk factors were documented in the discharge plan. A discharge meeting took place prior to the resident discharge and this was attended by the resident, the key worker, the relevant members of the MDT, and the resident representative. A comprehensive assessment was completed prior to discharge, and it included documented psychiatric and psychological needs, a mental state exam, and a risk management
plan. The discharge was coordinated by the resident’s key worker and comprehensive discharge summaries were sent to the residents’ general practitioners within 14 days. These summaries contained details of the residents’ diagnosis, prognosis, medication, and follow-up arrangements.

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

a) The approved centre was non-compliant with Regulation 18, Transfer of Residents, 30.1.
b) The discharge plan did not include the estimated date of discharge, 34.2.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 19: General Health

<table>
<thead>
<tr>
<th>Reason ID: 10000310</th>
<th>The six-monthly general health assessment was inadequately completed in a number of cases. Family and personal history, BMI, weight, waist circumference, nutritional status, and dental check were not completed and documented in all cases, 19(1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Corrective Action</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td></td>
<td>New template insitu to meet requirements when completed in full. Memo requested by Acting Clinical Director to all NCHDs regarding the importance of all specific requirements.</td>
</tr>
<tr>
<td></td>
<td><strong>Achievable/Realistic</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Time-bound</strong></td>
</tr>
<tr>
<td></td>
<td>27/02/2020</td>
</tr>
<tr>
<td></td>
<td><strong>Audit 6 monthly and analysis.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Completed and on-going For Review in 6 months</strong></td>
</tr>
<tr>
<td></td>
<td><strong>27/02/2020</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Acting Clinical Director.</strong></td>
</tr>
</tbody>
</table>
### Regulation 8: Residents' Personal Property and Possessions

<table>
<thead>
<tr>
<th>Reason ID : 10000311</th>
<th>Records of residents' money stored within secure facilities were not up to date, 8 (3).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All records now updated by CNM2s. Records updated as per policy and meets requirements of regulation.</td>
</tr>
<tr>
<td></td>
<td>Achieved Completed 27/08/2019 CNM3 and CNM2s.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>CNM2 s to check processes in relation to limited amounts of money stored in secure facilities and records up to date. To be audited monthly, by 6 months. Discussed at CAPA Review Forum meeting.</td>
</tr>
<tr>
<td></td>
<td>Achievable - completed and on going 27/02/2019 CNM3 and CNM2s x 4.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000312</th>
<th>The registered proprietor did not ensure that provision was made for the safe keeping of all personal property and possessions. The property and possessions stored in the property rooms were not labelled, therefore the property owner was unidentifiable, 8 (6). Records of residents' personal property were not documented within each residents' personal file, 8 (3).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Three staff members allocated responsibility to oversee the processes as per policy, in Regards to regulation 8 and the storing of property. Monthly Audit Realistic 30/09/2019 CNM3.</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID : 10000323</th>
<th>There was an insufficient number of toilets and showers for residents in the High Dependency Unit, and this was not conducive to the wellbeing of residents 22 (3).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Business plan to be put forward in relation to restructure of High Dependency Unit.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Importance of privacy and dignity of residents in the high dependency Unit discussed with all clinical staff in relation to the number of toilets and showers in the HDU. All staff have signed to say that they have read and understood the policy on premises and privacy.</td>
</tr>
</tbody>
</table>
Regulation 26: Staffing

Reason ID: 10000314

<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>Memo issued to all staff regarding training. New dates to be provided. All heads of discipline to manage each disciplines records and forward to Head of Service.</td>
<td>Analysis every 4 months to be completed</td>
<td>Achievable Completed and on Going</td>
<td>29/08/2019</td>
<td>ADON APU</td>
</tr>
</tbody>
</table>

Corrective Action

| Preventative Action                                                                 | Analysis every 4 months to be completed                                      | Achievable and on-going Review 1 Year    | 28/08/2020       | Deployment.   |
| New training database to be introduced for CHO 3.                               |                                                                           |                                           |                  |                |
### Regulation 15: Individual Care Plan

<table>
<thead>
<tr>
<th>Reason ID : 10000316</th>
<th>For three of the ten ICPs reviewed, the ICP did not identify appropriate goals. In three ICPs, the care and treatment was not identified.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td><strong>Specific</strong> Care Plan training (extra focus on specific and appropriate goals) to meet criteria of regulation. Findings of the draft report sent to all consultants, all heads of disciplines and all staff. All multidisciplinary ICPs to identify specific goals. <strong>Measurable</strong> Monthly audit and analysis <strong>Achievable/Realistic</strong> Achievable and On Going <strong>Time-bound</strong> 28/02/2020 <strong>Post-Holder(s)</strong> A/ADON X2</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td><strong>Specific</strong> Continuous training as above <strong>Measurable</strong> Monthly audit and analysis <strong>Achievable/Realistic</strong> Achievable and on-going <strong>Time-bound</strong> 28/02/2020 <strong>Post-Holder(s)</strong> A/ADON X2</td>
</tr>
</tbody>
</table>
### Regulation 21: Privacy

**Reason ID : 10000318**

<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>New privacy panel for seclusion room continues to be sourced.</td>
<td>Quarterly premises and privacy analysis. CAPA review and progress meeting to monitor all CAPAs.</td>
<td>Achievable - Continuing to source same Review 6 months</td>
<td>28/02/2020</td>
<td>CNM3 and ADON APU. CAPA Review Group.</td>
</tr>
<tr>
<td>Appropriate Blinds / Curtains to be sourced.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>As above, staff to sign the Signature Log of relevant policies (Seclusion and Privacy)</td>
<td>Signature log</td>
<td>29/08/2019</td>
<td>CNM3</td>
</tr>
</tbody>
</table>
## Regulation 18: Transfer of Residents

### Reason ID: 10000319

Full and complete information about for one resident was not provided to the receiving facility during the transfer. The approved centre did not send a letter of referral, the residents’ care and treatment plan, or a list of the resident's current medications to the receiving facility on transfer, 18 (1).

<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>Checklist to ensure compliance available to all staff. Memo sent to all clinical staff in relation to the MHC findings on transfers.</td>
<td>Audit every 3 months and results to be sent to all teams and all CNM2s. To be standing item on agenda for staff meetings. CAPA meeting to review progress</td>
<td>Achieved and on-going. completed but will continue to audit</td>
<td>29/08/2019</td>
</tr>
</tbody>
</table>

| **Preventative Action** | All staff have signed to say that they have read and understood the policy on transfers. All staff emailed a copy of the transfer checklist. | completed | Realistic and completed | 29/08/2019 | CNM3 |
### Regulation 27: Maintenance of Records

**Reason ID: 10000325**

Records were not maintained in a manner to ensure completeness, accuracy, and ease of retrieval. One clinical file contained loose pages, and one clinical file was not in a logical sequence, 27(1).

<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>Six staff to be appointed to oversee maintenance of records. Training to continue on maintenance of records. Memo to all staff in relation to collective responsibility in adherence to this regulation.</td>
<td>CAPA Review meetings to monitor progress. Quarterly audit and analysis</td>
<td>Realistic Completed and on-going</td>
<td>29/08/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Training on the maintenance of records will be provided based on the policy and the regulation.</td>
<td>CAPA Review Forum to monitor progress.</td>
<td>Realistic Review in 6 months</td>
<td>28/02/2020</td>
</tr>
</tbody>
</table>
## Code of Practice on Admission, Transfer and Discharge to and from an approved centre

<table>
<thead>
<tr>
<th>Reason ID : 10000321</th>
<th>The discharge plan did not include the estimated date of discharge, 34.2.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Checklist now developed to ensure compliance and awaiting approval by senior management</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Estimated date of discharge to be discussed at all multidisciplinary team meetings. All teams informed.</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.