An Coillín
ID Number: AC0060

2019 Approved Centre Inspection Report (Mental Health Act 2001)
An Coillín
Westport Road
Castlebar
Co Mayo

Approved Centre Type: Continuing Mental Health Care/Long Stay
Most Recent Registration Date: 17 May 2019

Conditions Attached: None
Registered Proprietor: HSE
Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, CHO2 – Mental Health Services

Inspection Team:
Karen McCrohan, Lead Inspector
Martin McMenamin
Carol Brennan-Forsyth

Inspection Date: 17 – 19 September 2019
Inspection Type: Unannounced Annual Inspection
Previous Inspection Date: 31 July – 3 August 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711
Date of Publication: Monday 09 March 2020

2019 COMPLIANCE RATINGS

REGULATIONS
1. Compliant
2. Non-compliant
28. Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH

1. Compliant
4. Not applicable

CODES OF PRACTICE

2. Compliant
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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In brief

An Coillín was a 22-bed single-story standalone building, located beside Mayo University Hospital, in Castlebar, County Mayo. It provided continuing mental health care under the care of the Rehabilitation and Recovery multi-disciplinary team.

The approved centre has improved its compliance with regulations and codes of practice from 88% in 2017; 87% in 2018 to 97% in 2019, representing only one non-compliance. There were 19 compliances with regulations that were rated as excellent. An ethos of continuous improvement was evident within the approved centre, with staff fully engaged with this process.

Conditions to registration

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

Safety in the approved centre

- Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations and kitchen areas were clean.
- All healthcare professional staff were trained in Children First and the Mental Health Act.
- Medication was ordered, prescribed, stored and administered in a safe manner.
- Ligature points were minimised to the lowest practicable level, based on risk assessment.

However:

- Not all healthcare professional staff were trained in Fire Safety, Basic Life Support and the Management of Violence and Aggression. Fire safety training levels were concerning as only 33% of nursing staff had up-to-date training.
Appropriate care and treatment of residents

- Each resident had an excellent multi-disciplinary individual care plan developed and reviewed with the resident’s input.
- There was a wide range of therapeutic services and programmes which met the assessed needs of the residents. The approved centre had a dedicated Occupational Therapist (OT) Assistant from Monday to Friday, who facilitated the activity programme with a social worker. While the approved centre did not have a dedicated psychologist, psychology services could be accessed by referral as required. Therapeutic programmes included music therapy, an art group, a baking group, reminiscence, cognitive exercises, and a box fit exercise group. Residents had access to a dedicated OT activities room, an OT kitchen, a day room and a garden area.
- Each resident had a full physical examination and monitoring of their health status at least every six months. Residents on antipsychotic medication were monitored in line with best practice.
- For residents with special dietary requirements, an evidence-based nutrition tool was used to assess the residents on a monthly basis or more frequently, if indicated. The approved centre had access to a dietitian and Speech and Language Therapist (SALT) by referral.

Respect for residents’ privacy, dignity and autonomy

- There were private areas where residents could meet visitors.
- The approved centre was clean and there was a cleaning programme in place.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas, and noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment.
- All residents’ records inspected were secure, up-to-date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements.

Responsiveness to residents’ needs

- Residents were provided with a variety of wholesome and nutritious food and had at least two choices for meals.
- There were plenty of recreational activities for residents. These included art and crafts, open discussion groups, music from an external provider, social outings, TV, DVDs, a garden, and walks. In addition, the approved centre provided access to recreational activities during the weekend such as outings, walks, and coffee in the town.
• Written information about the approved centre, diagnoses and medications was available.
• There was an excellent complaints procedure in place.

### Governance of the approved centre

• An Coillín was part of Community Healthcare West, formerly known as Community Healthcare Organisation (CHO) 2, and was governed under the Mayo Mental Health Services.
• The Mayo Mental Health Services governance processes encompassed two core monthly meetings: the Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee meeting.
• There was also a local Multi-disciplinary Operational Group which encompassed the entire Rehabilitation and Recovery service. This was a forum to discuss local operational issues such as risk management, staff training and service development.
• The approved centre’s policies were developed by a multi-disciplinary steering Policies, Procedures, Protocols and Guidelines (PPPG) group in consultation with staff, with input from the Judgement Support Framework working group.
• The Judgement Support Framework working group had oversight of the auditing schedule; from which the approved centre had completed audits and analysis across all of the applicable regulations, rules and codes of practice.
• The person with responsibility for risk was identified and known by all staff. The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The multi-disciplinary team was involved in the development, implementation, and review of individual risk management processes.
• Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns occurring in the service.
• Resident and carer engagement was facilitated through regular resident community meetings, suggestion boxes, and engagement with the complaints process. All formal complaints were reviewed at the Mayo Mental Health Services Quality and Patient Safety Committee meeting, with relevant actions identified.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of new recreational activities, which included; a service user led music group, a visit to Kiltimagh Pet Farm and the ice-cream van’s visit to the approved centre.

2. Expansion of the therapeutic programme to include a baking group, a boxfit group and an imagination gym group.

3. Establishment of a ‘Seclusion and Physical Restraint’ working group and a ‘Physical Health Needs’ working group, within the wider Mayo Mental Health Service.

4. Introduction of nursing staff training in clinical supervision.

5. Procurement of new furniture for the day room.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

An Coillín was a single-story standalone building, located beside Mayo University Hospital, in Castlebar, County Mayo. The unit was registered with the Mental Health Commission for the provision of continuing mental health care. All of the residents were under the care of the Rehabilitation and Recovery multi-disciplinary team.

The unit accommodated 22 residents at full capacity, in which residents were accommodated in a number of single en suite bedrooms and shared dormitories. Resident areas included a spacious day room, a dining room, an activities room, an occupational kitchen, an oratory and a large enclosed garden.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>22</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>21</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>19</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

An Coillín was part of Community Healthcare West, formerly known as Community Healthcare Organisation (CHO) 2, and was governed under the Mayo Mental Health Services. There were four approved centres within the Mayo Mental Health service. The approved centre’s registered proprietor nominee was the Mayo Mental Health Services General Manager.

The Mayo Mental Health Services governance processes encompassed two core monthly meetings: the Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee meeting. Both meetings were scheduled monthly and the meeting minutes were provided to the inspection team. The minutes evidenced discussions on key issues such as: risk management; quality initiatives; complaints and compliments; policies, procedures, protocols, and guidelines; regulatory compliance; resource requirements; and performance monitoring. Governance was further enhanced by a local Multi-disciplinary Operational Group meeting, which encompassed the entire Rehabilitation and Recovery service. The Multi-disciplinary Operational Group met monthly, with the exception of the summer months of July and August. This meeting was a forum to discuss local operational issues such as risk management, staff training and service development. Additional working groups and committees, such as the Health and Safety Committee, Multi-Disciplinary Therapeutics working group, Judgement Support Framework working group and the Children First Operational Steering Committee, reported into the relevant forums.
The approved centre’s policies were developed by a multi-disciplinary steering Policies, Procedures, Protocols and Guidelines (PPPG) group in consultation with staff, with input from the Judgement Support Framework working group. All of the required operating policies and procedures were reviewed within the required three-year period. The Judgement Support Framework working group had oversight of the auditing schedule; from which the approved centre had completed audits and analysis across all of the applicable regulations, rules and codes of practice.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The Mental Health Commission’s Governance Questionnaire was issued to the approved centre’s Heads of Discipline in advance of the inspection. The Heads of Discipline outlined regular engagement with staff and clear lines of responsibility. Visits from the Heads of Disciplines, to the approved centre, ranged from weekly to occasional visits. Appropriate staffing resources were available, with the exception of psychology. The Rehabilitation and Recovery’s multi-disciplinary team did not have a psychologist assigned to An Coillín. All healthcare professional staff were trained in Children First and the Mental Health Act. Not all healthcare professional staff were trained in Fire Safety, Basic Life Support and the Management of Violence and Aggression. Fire safety training levels were concerning as only 33% of nursing staff had up-to-date training.

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

Resident and carer engagement was facilitated through regular resident community meetings, suggestion boxes, and engagement with the complaints process. All formal complaints were reviewed at the Mayo Mental Health Services Quality and Patient Safety Committee meeting, with relevant actions identified.

An ethos of continuous improvement was evident within the approved centre. Nineteen regulations were rated as excellent on this inspection. The inspection highlighted an improvement from the previous year as the approved centre’s non-compliances were down from four to one. Regulation 26: Staffing was deemed non-compliant on this inspection.

### 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.
4.1 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>
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</thead>
<tbody>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

<table>
<thead>
<tr>
<th>Regulation</th>
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<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
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<tr>
<td>Regulation 5: Food and Nutrition</td>
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<tr>
<td>Regulation 6: Food Safety</td>
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<tr>
<td>Regulation 7: Clothing</td>
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<td>Regulation 8: Residents’ Personal Property and Possessions</td>
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<td>Regulation 9: Recreational Activities</td>
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<td>Regulation 10: Religion</td>
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<td>Regulation 11: Visits</td>
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<td>Regulation 12: Communication</td>
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<td>Regulation 14: Care of the Dying</td>
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<td>Regulation 15: Individual Care Plan</td>
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<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
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<tr>
<td>Regulation 19: General Health</td>
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<td>Regulation 21: Privacy</td>
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<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
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<td>Regulation 27: Maintenance of Records</td>
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<td>Regulation 29: Operating Policies and Procedures</td>
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<td>Regulation 30: Mental Health Tribunals</td>
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<td>Regulation 31: Complaints Procedures</td>
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</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy 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.

No resident requested to speak privately with the inspection team. However, the inspectors had the opportunity to engage with the residents informally throughout the inspection. The care and treatment provided was described positively by all of the residents. The only issue raised was in relation to one mattress, in which the resident reported that it was uncomfortable. The service had completed a mattress audit, which identified an action to purchase new mattresses.

No completed service user questionnaires were 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:

- General Manager (Registered Proprietor Nominee)
- Executive Clinical Director
- Area Director of Nursing
- Business Manager
- Occupational Therapy Manager
- Principal Social Worker
- Principal Psychologist
- Regulatory Compliance Advisor
- Nurse Practice Development Co-ordinator
- Acting Assistant Director of Nursing
- Acting Clinical Nurse Manager III (x2)
- Social Worker Team Leader
- Clinical Nurse Manager II
- Clerical Officer
- Infection Prevention and Control Nurse

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Any applicable information provided to the inspection team at the feedback meeting was included within the report.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs, including stickers with the resident’s name. The identifiers used were person specific, and did not include room number and physical location. Two appropriate resident identifiers were used when administering medication, medical investigations and providing other health care services. Additionally, an appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The approved centre used an alert sticker system for residents with the same or similar names.

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 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 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: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. There was a source of safe, fresh drinking water made available to residents at all times in easily accessible locations throughout the approved centre. In addition, hot meals were provided on a daily basis.

For residents with special dietary requirements, an evidence-based nutrition tool was used to assess the residents on a monthly basis or more frequently, if indicated. Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. The approved centre had access to a dietician and Speech and Language Therapist (SALT) by referral.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This 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. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was suitable and sufficient catering equipment in the approved centre. There were proper facilities for the refrigeration, storage, preparation and serving of food. Food was prepared in GMIT (Galway/Mayo Institute of Technology) and transported to the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Additionally, residents were provided with crockery and cutlery that was suitable to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 7: Clothing

The registered proprietor shall ensure that:
(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
(2) night clothes are not worn by residents during the day, unless specified in a resident’s individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents’ clothing were clean and appropriate to their needs. In this regard, there was a laundry room within the approved centre, which contained a washing machine and a dryer. However, residents sent their laundry to an external laundry provider. Residents were provided with emergency personal clothing that was appropriate and took account of their personal preferences, dignity, bodily integrity, and religious and cultural practices. All residents in the approved centre were observed to be wearing their day clothes during 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 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 June 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 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: A resident’s personal property and possessions were safeguarded when the approved centre assumed responsibility of them. Secure facilities were provided for the safekeeping of the resident’s monies, valuables, personal property and possessions, as necessary. The resident was entitled to bring personal possessions with them, the extent of which was agreed at admission. Where any money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained. Where possible, this was counter-signed by the resident or their representative.

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile, including art and crafts, open discussion groups, music from an external provider, social outings, TV, DVDs, a garden, and walks. In addition, the approved centre provided access to recreational activities during the weekend such as outings, walks, and coffee in the town. Information on recreational activities was provided to residents in an accessible format through pictorial timetables around the unit. Residents were involved in the development, implementation and maintenance of recreational activities through community meetings discussions.

Individual risk assessments were completed for residents where deemed appropriate, in relation to the selection of appropriate activities. Recreational activities provided were appropriately resourced; for example, residents had access to cooking or baking in the occupational therapy kitchen. Indoor and outdoor exercise was provided through walks outside and a static floor pedal machine. Documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file, as 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.
The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

**INSPECTION FINDINGS**

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

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

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

**Evidence of Implementation**: Residents’ rights to practice religion were facilitated within the approved centre, insofar as was practicable: the approved centre had an oratory and mass was held every Tuesday and every second Sunday at 10am. Religious needs were assessed on admission, and residents had access to a multi-faith chaplain as required. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all 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 May 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 visits, as set out in the policy.

Monitoring: Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times in the approved centre were appropriate and reasonable, and the approved centre was flexible in terms of facilitating visits outside of the times that were publicly displayed. At the time of inspection, there were no visiting restrictions implemented. A separate visitors’ room was provided for residents to meet visitors, unless there was an identified risk to the resident, others, or a health and safety risk. The separate visitors’ room was suitable for visiting children. Appropriate steps were taken to ensure the safety of residents and visitors during visits. In addition, children visiting the approved centre were accompanied at all times to ensure their safety and this was communicated to relevant individuals publicly.

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 operational policy in relation to resident communication. The policy was last reviewed in June 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 had access to mail, fax, and telephone. The approved centre had a handheld phone, which residents could utilise to make phone calls in private. While the approved centre did not have a communal computer or Wi-Fi access, residents could access the internet in the nurses’ station, under supervision of staff, if required. While no resident had any identified risks regarding their external communication at the time of inspection, individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication, and documented in the individual care plan. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others. In this regard, no resident had had their communication examined at the time of 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 be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in June 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

As no search had been conducted in the approved centre since the last inspection the monitoring and evidence of implementation pillars were not applicable.

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

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.
(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.
(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.
(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.
(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

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

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

Monitoring: Analysis was completed to identify opportunities to improve the processes for the care of the dying.

Evidence of Implementation: The clinical file of one resident who died in Mayo University Hospital was inspected. The resident became unwell and was transferred to the Emergency Department. The sudden death of a resident was managed in accordance with legal requirements, and resident’s religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident’s representatives, family, or next of kin. In addition, support was given to other residents and staff following a resident’s death. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 15: Individual Care Plan

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in May 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Ten ICPs were inspected and, in all cases, the residents had been in the approved centre for many years. ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing care and treatment. ICPs also identified the resources required to provide the care and treatment identified.

ICPs identified a key worker, referred to locally as a care coordinator, to ensure continuity in the implementation of a resident’s ICP. A risk management plan was developed for each resident. ICPs included a preliminary discharge plan, where appropriate. ICPs were reviewed by the MDT in consultation with the resident every six months. Residents in the approved centre had access to their ICPs and were kept informed of any changes. When a resident declined or refused a copy of their ICP, this was recorded, including the reason, if given.

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

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

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

**Evidence of Implementation:** The approved centre had a dedicated Occupational Therapist (OT) Assistant from Monday to Friday, who facilitated the activity programme. An OT attended the approved centre once a week. A music therapist ran sessions on a weekly basis, an art teacher ran two sessions per week and the social worker took residents out on social trips. While the approved centre did not have a dedicated psychologist, psychology services could be accessed by referral as required. At the time of the inspection, the residents’ individual care plans (ICPs) did not indicate an assessed need for psychology.

The therapeutic services and programmes provided by the approved centre were evidence-based and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Therapeutic programmes included music therapy, an art group, a baking group, reminiscence, cognitive exercises, and a box fit exercise group.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Residents had access to a dedicated OT activities room, an OT kitchen, a day room and a garden area. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes in residents’ ICPs or clinical files. In this regard, each session was assessed using the OT Task Observation Scale, and records of participation were kept for each resident.

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred to another facility was inspected. An assessment of the resident was completed prior to transfer, including individual risk assessment relating to the transfer and the resident’s needs. Documented consent of the resident to transfer, or justification as to why consent was not received, was available. Full and complete written information for the transferred resident was sent from the approved centre to the receiving facility. Information was sent in advance or accompanied the resident upon transfer, to a named individual. The following information was issued, with copies retained as part of transfer documentation: a letter of referral, including a list of current medications; a resident transfer form; and required medication for the resident during the transfer process. Copies of all records relevant to the resident transfer were retained in the resident’s clinical file. However, no checklist pertaining to the transfer was evident within the clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
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 and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in December 2017. The medical emergencies policy was last reviewed in December 2017. The policies and procedures 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 tray and staff had access at all times to an Automated External Defibrillator (AED). Weekly checks were completed on the resuscitation tray and on the AED. All residents were registered with a General Practitioner (GP), although health care was managed by Non-Consultant Hospital Doctors (NCHDs). Residents’ physical needs were reflected in their ICPs.

The clinical files of five residents, who had been cared for in the approved centre for six months or more, were inspected. All residents had a six-monthly physical examination. The six-monthly general health assessments documented the following: physical examination; family and personal history, Body Mass Index (BMI), weight, and waist circumference; blood pressure; smoking status; nutritional status, including diet and physical activity and sedentary lifestyle; medication review, with pharmacy input; and dental health.

For residents on antipsychotic medication, there was an annual assessment of the following, unless a more regular review was indicated by physical examination: glucose regulation (fasting glucose/HbA1c); blood lipids; electrocardiogram (ECG); and prolactin. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. In addition, records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.
Residents could access national screening programmes that were available according to age and gender, including, but not limited to, the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

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 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:
   (a) details of the resident’s multi-disciplinary team;
   (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
   (c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
   (d) details of relevant advocacy and voluntary agencies;
   (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of information to residents. The policy was last reviewed in November 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The resident information booklet included details of: housekeeping arrangements, including arrangements for personal property and mealtimes; complaints procedure; visiting times and arrangements; and relevant advocacy and voluntary agencies. It did not, however, contain information on residents’ rights. Residents were provided with the details of their multi-disciplinary team. They were also provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. As such, the justification for restricting information regarding a resident’s diagnosis was documented in the clinical file.

The content of the 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, and there was a list of services available for staff.

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

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

INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** Residents were called by their preferred name in the approved centre, and the general demeanour of staff and manner in which they communicated with residents was appropriate, as was staff appearance and dress. Staff demonstrated discretion when discussing a resident’s condition or treatment needs, and sought residents’ permission before entering their rooms, as appropriate. All residents wore clothes that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas, and noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

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 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. Residents had access to personal space and communal rooms were appropriately sized and furnished to remove excessive noise. Not all of the resident bedrooms were appropriately sized to address the resident needs. Some of the residents were accommodated in shared dormitories; this infrastructure was deemed inadequate by the approved centre. There was sufficient space for residents to move about, including outdoor spaces. There was a sufficient number of toilets and showers for residents in the approved centre. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised throughout the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Backup power was available to the approved centre.
The approved centre had a designated sluice room and a designated cleaning room. The approved centre provided assisted devices and equipment including hoists, slings and mobility equipment to address resident needs. Remote or isolated areas of the approved centre were monitored.

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 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

Training and Education: All nursing and medical staff as well as pharmacy staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical 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 and medical staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

Evidence of Implementation: The MPARs for ten of the residents were inspected. A record of allergies or sensitivities to any medications, including if the resident had no allergies. A Medication Prescription and Administration Record was maintained for each resident and detailed two appropriate resident identifiers and the generic name of the medication and preparation, where applicable. All entries in the MPAR were legible, and written in black, indelible ink. 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. A prescription was not altered where a change was required. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines were administered by a registered nurse or registered medical practitioner.

Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident’s pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration, and expired medications were not administered. Direction to crush medication was only accepted from the resident’s medical practitioner.

Where applicable, a medical practitioner provided a documented reason why medication was to be crushed, and a pharmacist was consulted about the type of preparation to be used. In addition, the medical practitioner documented in the MPAR that the medication was to be crushed. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. Food and drink was not stored in areas used for the storage of medication. Medication dispensed or supplied to the resident was stored securely in a locked storage unit.
(e.g. drugs trolley or drawers), with the exception of medication that was recommended to be stored elsewhere (e.g. refrigerator). The medication trolley and/or medication administration cupboard remained locked at all times and secured in a locked room.

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 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 policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in February 2019. It also had an associated safety statement, dated January 2019 – January 2020. The policy and the safety statement included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in February 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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

Evidence of Implementation: There was an organisational chart in place which showed the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications to do their jobs. 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. An appropriately qualified staff member was on duty and in charge at all times.

The number and skill mix of staffing was not appropriate to meet resident needs as the approved centre's multi-disciplinary team did not have an assigned psychologist. The approved centre identified this issue as a risk and it was documented within the local risk register. A written staffing plan was available, which contained all of the requirements. Agency staff were used and there was a comprehensive contract between the approved centre and the registered staffing agency used.
Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed for all staff. Not all health care professionals had up to date training in fire safety, Basic Life Support and the Management of violence and aggression. All healthcare professional staff were trained in the Mental Health Act and Children First.

<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 (21)</td>
<td>13 62%</td>
<td>7 33%</td>
<td>17 81%</td>
<td>21 100%</td>
<td>21 100%</td>
</tr>
<tr>
<td>Consultant Psychiatrist (1)</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
</tr>
<tr>
<td>Medical (1)</td>
<td>1 100%</td>
<td>0 0%</td>
<td>0 0%</td>
<td>1 100%</td>
<td>1 100%</td>
</tr>
<tr>
<td>Occupational Therapist (2)</td>
<td>2 100%</td>
<td>2 100%</td>
<td>2 100%</td>
<td>2 100%</td>
<td>2 100%</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
</tr>
</tbody>
</table>

Staff were trained in manual handling, care of residents with an intellectual disability, infection control and prevention, risk management and the protection of children and vulnerable adults. Staff were not trained in residents’ rights, recovery-centred approaches to mental health care and treatment, end of life care and incident reporting. All staff training was documented.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Coillín</td>
<td>CNM 3</td>
<td>1</td>
<td>1 (Shared)</td>
</tr>
<tr>
<td></td>
<td>CNM 2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2 (+1 floating)</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Occupational Therapist (OT).*

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

a) The registered proprietor did not ensure that all healthcare professional staff were trained in Basic Life Support, fire safety and management of violence and aggression, 26(4).

b) The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate as the approved centre’s multi-disciplinary team did not have an assigned psychologist, 26(2).
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 in relation to the maintenance of records. The policy was last reviewed in January 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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 had been trained in best-practice record keeping.

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

Evidence of Implementation: All residents’ records inspected were secure, up-to-date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Clinical files were stored in the secure nurses’ office. Resident records were reflective of the residents’ current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence, and were maintained in good order with no loose pages. In this regard, the approved centre used addressographs as identifiers and had an index page and a divider system. Resident records were maintained appropriately and were written legibly in black, indelible ink, and readable when photocopied.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorized access or use. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.
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 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 register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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

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

INSPECTION FINDINGS

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

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

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

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

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

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

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

COMPLIANT
Quality Rating: Excellent
Regulation 30: Mental Health Tribunals

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in January 2018. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints. The policy was last reviewed in November 2018. The policy 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. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed on the noticeboard, and it was detailed within the residents’ 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.

All complaints were handled promptly, appropriately and sensitively. Where complaints could not be addressed by the nominated person, they would be escalated in accordance with the approved centre’s policy.

COMPLIANT
Quality Rating Excellent
The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints, apart from minor complaints, were dealt with by the nominated person 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 would deal with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process made available to them.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan. The complainant’s satisfaction or dissatisfaction with the investigation findings was documented.

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 March 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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

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

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

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. Incidents were reviewed for any trends or patterns occurring in the service.

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 pillar.
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

Compliant

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

INSPECTION FINDINGS

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

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

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
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: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated July 2019. The policy had been reviewed annually and included details of the following:

- The provision of information to residents regarding physical restraint.
- The individuals authorised to initiate and conduct physical restraint.

Training and Education: There was documented evidence to indicate that all staff involved in physical restraint had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: Three episodes of physical restraint were inspected. These indicated the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others. Episodes of physical restraint were initiated after staff had first considered other interventions and following a risk assessment. Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint.

All residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. In all three episodes, the clinical practice form for physical restraint was completed by the person initiating and ordering the use of physical restraint no later than three hours after the episode. The clinical practice forms were signed by the consultant psychiatrist within the required 24-hour timeframe.

Where applicable, the residents’ next of kin or representative were informed of the use of physical restraint as soon as was practicable and with the residents’ consent. 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 each episode. All residents were afforded the opportunity to discuss the episode of restraint with members of their MDT as soon as was practicable. All uses of physical restraint were clearly recorded in the clinical practice forms and recorded within clinical files.

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation:

Admission: The approved centre had a key worker system in place. The admission of one resident was inspected as part of the inspection process. The resident was admitted on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included a full physical examination, the presenting problem, past psychiatric history, medical history, current and historic medication, current mental health state, a risk assessment and an assessment of the resident’s social and housing circumstances. The resident’s family members, carer and/or advocate were involved in the admission process, with the resident’s consent.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary meeting, and the resident’s family. A comprehensive pre-discharge assessment was completed, which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan.

There was appropriate multi-disciplinary team input into discharge planning. A comprehensive discharge summary was issued within 14 days, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID: 10000870</th>
<th>The registered proprietor did not ensure that all healthcare professional staff were trained in Basic Life Support, fire safety and management of violence and aggression, 26(4).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>An updated 2020 training schedule has being developed incorporating all mandatory training. This includes a one day programme which covers BLS, Manual Handling Practical, Risk Management, Open Disclosure and Hand Hygiene. Four new trainers are now providing Therapeutic Management of Violence and Aggression (TMVA) training 3 times a month. Staff facilitated and prompted to complete Online training. Update of training records 3 monthly by line managers. Influenced by safe staffing levels. Clinical emergencies can prevent release of staff at short notice. Staff returning form leave may have to wait for next scheduled training.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Staff facilitated to attend/complete all mandatory training. On-going schedule of training available to staff. Update of training records 3 monthly by line managers. Influenced by safe staffing levels. Clinical emergencies can prevent release of staff at short notice. Staff returning form leave may have to wait for next scheduled training.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000871</th>
<th>The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate as the approved centre's multi-disciplinary team did not have an assigned psychologist, 26(2).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>0.25 psychology post assigned to An Coillin. The Psychologist Audit of Regulation 26 in May 2020 Achieved</td>
</tr>
</tbody>
</table>

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<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>An updated 2020 training schedule has being developed incorporating all mandatory training. This includes a one day programme which covers BLS, Manual Handling Practical, Risk Management, Open Disclosure and Hand Hygiene. Four new trainers are now providing Therapeutic Management of Violence and Aggression (TMVA) training 3 times a month. Staff facilitated and prompted to complete Online training. Update of training records 3 monthly by line managers. Influenced by safe staffing levels. Clinical emergencies can prevent release of staff at short notice. Staff returning form leave may have to wait for next scheduled training.</td>
<td>Update of training records 3 monthly by line managers. Influenced by safe staffing levels. Clinical emergencies can prevent release of staff at short notice. Staff returning form leave may have to wait for next scheduled training.</td>
<td>30/04/2020</td>
<td>Heads of Departments, Practice Development and line managers.</td>
<td></td>
</tr>
<tr>
<td>Staff facilitated to attend/complete all mandatory training. On-going schedule of training available to staff. Update of training records 3 monthly by line managers. Influenced by safe staffing levels. Clinical emergencies can prevent release of staff at short notice. Staff returning form leave may have to wait for next scheduled training.</td>
<td></td>
<td>30/04/2020</td>
<td>Heads of Departments, Practice Development and line managers.</td>
<td></td>
</tr>
<tr>
<td>0.25 psychology post assigned to An Coillin. The Psychologist Audit of Regulation 26 in May 2020 Achieved</td>
<td></td>
<td>31/12/2019</td>
<td>Principal Psychologist MMHS</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Escalated to senior managers and on the risk register.</td>
<td>Audit of Regulation 26 in May 2020</td>
<td>Achieved</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------</td>
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<td>------------</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.