Cappahard Lodge
ID Number: AC0071

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Cappahard Lodge
Tulla Road
Ennis

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

Most Recent Registration Date: 1 October 2017

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Mr Maurice Hoare, General Manager, Mid West Mental Health Services

Inspection Team:
Mary Connellan, Lead Inspector
Martin McMenamin
Raj Ramasawmy

Inspection Date: 13 – 16 August 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 13 – 16 March 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Monday 06 January 2020

2019 COMPLIANCE RATINGS

REGULATIONS
3

RULES AND PART 4 OF THE MENTAL HEALTH
26

CODES OF PRACTICE
2

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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In brief

Cappahard Lodge was located in an urban area on the outskirts of Ennis town, Clare. It was formerly a nursing home and had single bedroom accommodation for all the residents. Most of the residents had resided in the approved centre for a number of years. The approved centre was registered for 32 beds but had 15 residents at the time of admission.

There were two mental health teams: psychiatry of old age and a rehabilitation and recovery team. The latter had the majority of residents and provision was underway for the psychiatry of old age residents to go to nursing homes in line with their changing care needs. The Clare North Tipperary management team had commenced on a review, which included a focus on rehabilitation and recovery for the residents of the approved centre and the wider service.

Cappahard Lodge accepted transfer of residents from the Acute Psychiatric Unit (APU) to provide sleeping accommodation, in order to alleviate bed shortages in the APU. Cappahard Lodge is not suitable to provide care for acutely mentally ill people.

The approved centre had demonstrated impressive improvement in compliance with regulations, rules and codes of practice over the previous 3 years: 65% compliance in 2017; 90% compliance in 2018 and 93% compliance in 2019. There were 15 compliances with regulations rated as excellent.

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

**Condition 1:** To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Finding on this inspection:** The approved centre was in breach of Condition 1 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Safety in the approved centre
• Food safety was audited regularly. Kitchen areas were clean and had appropriate food and equipment storage facilities.
• Medication was ordered, prescribed, stored and administered in a safe manner.
• Environmental hazards were minimised.
• There was an emergency plan in place that included an evacuation plan.

However:

• Ligature anchor points were evident in the approved centre. Although the residents would be considered low risk, the approved centre accepted residents transferred from the local acute in-patient unit for the purposes of providing sleeping accommodation.
• Not all healthcare professionals who worked in or attend the approved centre were trained in: fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act (2001).

**Appropriate care and treatment of residents**

• Each resident had an individual care plan, which was developed by the multi-disciplinary team in conjunction with the resident. Each care plan outlined the resident’s needs, goals, interventions to address the goals and the resources required.
• An activities nurse provided a programme of activities that was recreational with therapeutic benefits. The occupational therapist facilitated a weekly group and an art therapist attended twice weekly. There was a separate, dedicated room containing facilities and space for individual and group therapies.
• Residents had access to occupational therapy, social work and clinical psychology on an individual basis as required. Most residents had been assessed as not requiring these interventions at the time of inspection.
• A GP visited the approved centre regularly. At a minimum, a six-monthly health assessments had been completed which included BMI, weight and waist circumference. These also detailed family and personal history, blood pressure, smoking and nutritional status and review of medication. An annual assessment of dental health had been completed. For those residents on antipsychotic medication an assessment of glucose regulation, blood lipids and prolactin levels were recorded.

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

• Each resident had a single bedroom. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Residents were facilitated to make private phone calls.
• Residents had access to personal space that included appropriately sized communal rooms, and to shared space in the form of well-lit and comfortably heated and ventilated communal rooms. There was sufficient space for residents to move about, including two outdoor gardens. There were private areas for the residents to meet visitors.

• There was a cleaning schedule and the approved centre was clean, hygienic, and free from offensive odours.

• Residents’ records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured.

• Physical restraint was carried out in compliance with the relevant code of practice.

However:

• The approved centre had not been kept in a good state of repair externally and internally. Externally the gardens were overgrown, with bushes and shrubbery not maintained. A large number of weeds were noted among the paving. Broken garden furniture was observed. There was a programme of decorative maintenance, cleaning, decontamination, and repair of assistive equipment, but there was no programme of general maintenance.

Responsiveness to residents’ needs

• The approved centre was bungalow style, built around an inner courtyard. There was access to a second grassed garden, activity and therapy rooms, sitting rooms and adequate bathroom and toilet facilities. The approved centre had been painted since the last inspection, all the toilets had been refurbished and an oratory, a physical examination room and a hairdressing room had been opened.

• There was written information about the approved centre, mental health diagnoses and medication.

• There was a robust complaints procedure in place.

• Recreational activities were available for residents, both during the week and at the weekend. These included a newspaper group, bingo, card games, movies, walks and outings. The approved centre had transport available for use by staff.

• A homely tea and coffee area had been developed in one of the main sitting areas for residents to access freely.

Governance of the approved centre

• The approved centre was under the governance of the Mid West Mental Health Service Management team which encompassed counties Limerick, Clare and North Tipperary. There was a local management team for Clare and North Tipperary region. There was an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the wider service.
- Service user representation was included in the governance structures with the area lead for mental health engagement on the Mid West Mental Health Service executive management team and the Clare North Tipperary management team.
- There was a programme of ongoing training and development in risk management since the last inspection. The approved centre inputted all risks into the National Incident Management System (NIMs) via the risk advisor.
- There was no system of performance appraisal for staff in the approved centre. Instead, performance issues were addressed through clinical supervision. Staffing shortages were acknowledged as an ongoing challenge; however, this was mitigated for nursing with the use of overtime and agency staff. There was an emphasis on education and training.
- Nursing staff conducted audit cycles.
- There was a wider service policy procedure and protocol group with sub groups working on various policies. These included membership of staff from the approved centre.

However:

- Although the risk register was reviewed at least quarterly by senior nursing staff within the approved centre, the mechanism for review by the Clare North Tipperary management team was not clear. The risk register had not been discussed at the Clare North Tipperary Management Team meetings. Records indicated that the last review by the executive management of the approved centre’s risk register was June 2018.
- The approved centre did not hold regular business meeting and documents and the rehabilitation team business meeting had not taken place in 2019. The Clare mental health service Health, Safety and Fire Management meeting had also not taken place in 2019.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A religious prayer room had been opened in the approved centre.

2. A room had been refurbished and furnished for use as a clinical assessment and physical examination room.

3. A room had been refurbished and furnished for hairdressing, barber and beauty treatments for the residents and was aptly named ‘Shampoo’.

4. A weekly GP clinic had commenced in the approved centre for non-emergency consultations.

5. In consultation with the residents and the catering department a healthy eating programme had been introduced.

6. An activities nurse had commenced in the approved centre to deliver and facilitate recreational and therapeutic activities and programmes for the residents.

7. A homely tea and coffee area had been developed in one of the main sitting areas for residents to access freely. On this theme, afternoon tea events were organised along with visits to the approved centre from a local ice cream van.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located in an urban area on the outskirts of Ennis town, Clare. Formerly a nursing home, it comprised of single bedroom accommodation for all the residents. It was bungalow style built around an inner courtyard. There was access to a second grassed garden, activity and therapy rooms, sitting rooms and adequate bathroom and toilet facilities. The approved centre had been painted since the last inspection, all the toilets had been refurbished and an oratory, a physical examination room and a hairdressing room had been opened.

There were two mental health teams; psychiatry of old age and a rehabilitation and recovery team. The latter had the majority of residents and provision was underway for the psychiatry of old age residents to go to nursing homes in line with their changing care needs. Most of the residents had resided in the approved centre for a number of years. Despite the majority of residents under the care and treatment of the rehabilitation team, the care and treatment provided was primarily nurse-led. An occupational therapy group was facilitated once weekly but had been cancelled due to annual leave the week of the inspection and for the two subsequent weeks. No other allied health professional inputted into the therapeutic programme.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>32</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>15</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>14</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was under the governance of the Mid West Mental Health Service Management team which encompassed counties Limerick, Clare and North Tipperary. There were two local management teams and one was for the collective Clare and North Tipperary region. There was an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the wider service.

The approved centre did not hold regular business meeting and documents evidenced that the rehabilitation team business meeting had not taken place in 2019. The Clare mental health service Health, Safety and Fire
Management meeting had also not taken place in 2019. It was noted that a number of other meetings had been convened to include a Clare North Tipperary Quality and Safety Committee, a Senior Nurse Management meeting and a Corrective and Preventative Actions (CAPA) Committee. The Clare North Tipperary Management meetings were held monthly and Cappahard Lodge and the Rehabilitation service was a standing item on the agenda. In recent months the Clare North Tipperary management team had embarked on a review which included a focus on rehabilitation and recovery for the residents of the approved centre and the wider service. This review was ongoing at the time of the inspection.

The inspection team sought to meet with or speak with all heads of discipline during the inspection. The inspection team contacted all the heads of discipline and met or spoke with the following individuals:

- Principal Social Worker
- Clinical Director
- Occupational Therapy Manager
- Area Lead for Mental Health Engagement
- Risk Advisor

The Mental Health Commission’s Governance questionnaire had only been completed and returned by the approved centre’s senior clinical psychologist.

The organisational chart outlined the governance structure. Reporting procedures throughout the approved centre were clearly defined. Service user representation was embedded in the governance structures with the area lead for mental health engagement on the Mid West Mental Health Service executive management team and the Clare North Tipperary management team.

Risk management processes were evident with a programme of ongoing training and development in risk management since the last inspection. The approved centre inputted all risks into the National Incident Management System (NIMs) via the risk advisor. Although the risk register was reviewed at least quarterly by senior nursing staff within the approved centre, the mechanism for review by the Clare North Tipperary management team was not clear. It had not been discussed at the Clare North Tipperary Management Team meetings as would have been expected. Records indicated that the last review by the executive management of the approved centre’s risk register was June 2018.

There was no system of performance appraisal for staff in the approved centre. Instead, it was reported that performance issues were addressed through clinical supervision. Staffing shortages were acknowledged as an ongoing challenge; however, this was mitigated for nursing with the use of overtime and agency staff. There was no social worker or psychologist on the psychiatry for old age team. Access to the appropriate allied health professional was available from another team if required.

There was good emphasis on education and training. It was noted that it was primarily nursing staff that were involved in the audit cycles. There was a wider service policy procedure and protocol group with sub groups working on various policies. These included membership of staff from the approved centre.
3.3 Reporting on the National Clinical Guidelines

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

#### 4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 22: Premises</td>
<td>X  Moderate</td>
<td>X  High</td>
<td>X  Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X  Moderate</td>
<td>X  Moderate</td>
<td>X  Moderate</td>
</tr>
</tbody>
</table>

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

#### 4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

- Regulation 4: Identification of Residents
- Regulation 6: Food Safety
- Regulation 7: Clothing
- Regulation 8: Residents’ Personal Property and Possessions
- Regulation 9: Recreational Activities
- Regulation 10: Religion
- Regulation 11: Visits
- Regulation 12: Communication
- Regulation 14: Care of the Dying
- Regulation 18: Transfer of Residents
- Regulation 19: General Health
- Regulation 20: Provision of Information to Residents
- Regulation 21: Privacy
- Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
- Regulation 31: Complaints Procedures

#### 4.3 Areas that were not applicable on this inspection
<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As 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.
- The minutes of the monthly resident meetings were reviewed.

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

The inspection team met with two residents formally and engaged with a number of other residents informally throughout the inspection process. Resident feedback was positive and overall complimentary about the care and treatment in the approved centre. Minutes of the resident meetings reviewed while overall complimentary, indicated that residents would have liked more occupational therapy groups.

A member of the inspection team spoke with the area lead for mental health engagement who had received positive feedback from family members of residents in the approved centre. This feedback related specifically to the staff of the approved centre and acknowledged the care provided within a community ethos and culture.

The IAN did not regularly visit the approved centre but a notice with contact details was displayed. There was also a notice detailing the Support and Advocacy Service (SAGE) contact telephone number.

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:

- Principal Social Worker
- Area Lead of Mental Health Engagement
- Senior Executive Officer
- Head of Service and Registered Proprietor
- Occupational Therapy Manager
- Acting Assistant Director of Nursing
- Clinical Nurse Manager 11
- Clinical Director
- Area Director of Nursing

Apologies were received on behalf of the executive clinical director, the principal psychologist, the director of nursing, the two consultant’s psychiatrists and the general manager.

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 clarifications have been incorporated into the relevant section of the report.

The management acknowledged that the approved centre had been used to sleep residents overnight from another approved centre. There was discussion as to the difficulties this practice brought and the disruption to the residents from both approved centres.

The inspection team were informed that small amounts of capital expenditure would be made available to remedy some of the identified maintenance issues.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

**INSPECTION FINDINGS**

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

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 identifiers appropriate to the resident group profile and individual resident needs. The preferred identifiers used for each resident were detailed within the residents’ clinical files. Identifiers were person-specific and included name, photograph and date of birth. Identifiers were appropriate to residents’ communication abilities. Two resident identifiers were used prior to the administration of medications and providing other health care services. A red sticker alert system was in place for residents with the same or similar name.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in April 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 food and nutrition, as set out in the policy.

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

Evidence of Implementation: The approved centre menus were appropriately approved by a dietician to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food, including food portions from the different food groups as per the food pyramid. A hot meal was provided every day and residents had at least two choices for meals. Food, including modified consistency diets was presented in a manner that was appealing in terms of texture, flavour and appearance. There was a source of safe, fresh drinking water available to residents. Hot and cold drinks were offered to residents on a regular basis and were readily available at all times.

For residents with special dietary requirements an evidence based nutrition assessment tool was used. Weight charts were implemented, monitored and acted upon for residents as appropriate. Nutritional and dietary needs were assessed where necessary and addressed in residents’ care plans. The needs of residents identified as having special nutritional requirements were not regularly reviewed by a dietician. Intake and output charts were maintained for residents where appropriate.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in January 2013. 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: Appropriate hand-washing areas were provided for catering services and protective equipment, including Personal Protective Equipment (PPE), was used during the catering process. Food was prepared and cooked in St Joseph’s Hospital and transported to the approved centre. There was suitable and sufficient catering equipment in place for the safe provision of food. Hygiene was maintained to support food safety requirements and there were proper facilities for the refrigeration, storage preparation, cooking and serving of food. Catering areas and associated food safety equipment were appropriately cleaned. Residents were provided with crockery and cutlery that was suitable to their 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 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 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. A record of residents wearing nightclothes during the day was maintained and monitored. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use their personal clothing. Residents’ clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that took account of their preferences, dignity, bodily integrity and religious and cultural practices. Residents changed out of nightclothes during day time hours unless specified otherwise in their individual care plans, however at the time of inspection no resident was prescribed night attire. Residents had an adequate supply of individualised clothing and there was a laundry service available to residents. This was located on the grounds of 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 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in September 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: A resident’s personal property and possessions are safeguarded when the approved centre assumes responsibility for them. Secure facilities were provided for the safe-keeping of the resident’s monies, valuables, personal property and possessions as necessary. On admission the approved centre compiled a detailed property checklist with each resident of their personal property and possessions.

Where money belonging to the resident was handled by staff, signed records of two staff issuing the money were retained. Residents were supported to manage their own property unless this posed a danger to the resident or others as indicated in their individual care plan and in accordance with the approved centre’s policy.

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 May 2019. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a 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, and were available on weekdays and during the weekend. These included a newspaper group, bingo, card games, movies, walks and outings. The approved centre had transport available for use by staff.

Information on activities was provided to residents in an accessible format that included the types and frequency of appropriate recreational activities available in the approved centre. Recreational activity programmes were developed, implemented and maintained for residents with resident involvement. Individual risk assessments were completed for residents in relation to the selection of appropriate activities. Resident decisions on whether or not to participate in the activities were respected and documented.

The recreational activities provided by the approved centre were appropriately resourced and there were opportunities for indoor and outdoor physical activities. Communal areas were provided for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the 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.
Regulation 10: Religion

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Resident rights to practice religion were facilitated within the approved centre insofar as was practicable. There were facilities provided within the approved centre for religious practice and residents had access to multi-faith chaplains. Residents had access to local religious services and were supported to attend if deemed appropriate and following risk assessment. Care and services that were provided within the approved centre were respectful of the resident’s religious beliefs and values. Any specific religious requirements relating to the provision of services, care and treatment were clearly documented. Each resident was facilitated to observe or abstain from religious practice in accordance with his or her wishes.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Visiting arrangements were publicly displayed, and were appropriate and reasonable. A separate visitors’ area directly off the entrance hall was provided where residents could meet visitors unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety. This was communicated to all relevant individuals publicly. The visiting area was suitable for visiting children.

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. 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, email and telephone unless otherwise risk-assessed with due regard to the residents’ well-being, safety and health. Residents did not have access to Wi-Fi. 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. At the time of inspection, no residents had any risks associated with their external communication. The clinical director or senior staff members only examined incoming communication if there was reasonable cause to believe that the communication may result in harm to the resident or others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in May 2019.

The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

As there had been no searches in the approved centre since the previous 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 and protocols in relation to care of the dying. The policy was last reviewed in April 2018. The policy and protocols included all of the requirements of the Judgement Support Framework.

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Systems analysis was undertaken in the event of a sudden or unexpected death in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The clinical file of a resident who had died in the approved centre was reviewed. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of the resident. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

Support was given to other residents and staff following a resident’s death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame. The approved centre had established a remembrance area to acknowledge and recall those residents who had died.
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 June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. 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. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs did not include an individual risk management plan for each resident. As applicable, there was evidence of specific proforma physical risk assessments but none pertaining to psychiatric risk assessments.

Residents were assessed at admission and an ICP was drawn up by the multi-disciplinary team within seven days, following a comprehensive assessment. The ICPs identified the residents’ assessed needs and the goals and resources required to provide the care and treatment specified. The ICPs were reviewed by the MDT at least six-monthly. The residents’ did not generally attend their ICP review meeting. A key worker system was used to ensure continuity in the implementation of a resident’s ICP. The resident had access to their individual care plan and was kept informed of any changes. There was documentary evidence to indicate that each resident had been offered a copy of their ICP and that the resident had received or declined a copy of their individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.
Regulation 16: Therapeutic Services and Programmes

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in April 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** The range of services and programmes provided in the approved centre had not been 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 therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. A therapeutic programme was available to residents. A programme of activities that was recreational with therapeutic benefits was facilitated by an activities nurse. The occupational therapist facilitated a weekly group and an art therapist attended twice weekly. There was a separate, dedicated room containing facilities and space for individual and group therapies. A record was maintained of participation, engagement and outcomes achieved in the programme, within the resident’s individual care plan and nursing care plan.

Residents had access to occupational therapy, social work and clinical psychology on an individual basis as required. It was noted in the clinical files that most residents had been assessed as not requiring these interventions at the time of inspection.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in February 2018. It included all of the requirements of the Judgement Support Framework.

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

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

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

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 19: General Health

(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 October 2018. The medical emergencies policy was last reviewed in September 2018. 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 did not have an emergency trolley. Staff had access to an Automated External Defibrillator, which had been checked weekly. There was a record of any medical emergency since the last inspection.

Registered medical practitioners assessed residents’ physical health on admission, and general health needs were managed thereafter. A GP visited the approved centre regularly. At a minimum, a six-monthly health assessments had been completed which included BMI, weight and waist circumference. These also detailed family and personal history, blood pressure, smoking and nutritional status and review of medication. An annual assessment of dental health had been completed. For those residents on antipsychotic medication an assessment of glucose regulation, blood lipids and prolactin levels were recorded.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. National screening programme information was available, and residents could access national screening programmes, as applicable. Residents had access to a smoking cessation programme and supports.

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 and procedures in relation to the provision of information to residents, which was last reviewed in June 2018. The policy and procedures 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: An information booklet was provided to residents and their representatives on admission. This contained details of the housekeeping arrangements such as mealtimes, the complaints procedure, visiting times and arrangements, the arrangements for personal property, and details of the relevant advocate and voluntary agencies. The handbook addressed residents’ rights. Residents and their families were provided with information on their multi-disciplinary team.

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

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 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 June 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 and the general demeanour of staff was respectful and conducive to maintaining resident dignity. Staff appearance and dress was also appropriate. When discussing the resident’s condition or treatment needs, staff discretion was used at all times. Staff sought resident permission before entering their rooms. All residents were wearing 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 a resident. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. 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.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed
in September 2018. There was also a policy on ligature risk reduction that had been last reviewed in June
2018. The policies included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read
and understood the policy. Relevant staff interviewed 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: Residents had access to personal space that included appropriately sized
communal rooms, and to shared space in the form of well-lit and comfortably heated and ventilated
communal rooms. There was sufficient space for residents to move about, including two outdoor gardens.
Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards,
including large open spaces, slippery floor, hard and sharp edges, hard or rough surfaces were minimised
in the approved centre. Ligature points had not been minimised, to the lowest practicable level.

The approved centre had not been kept in a good state of repair externally and internally. Externally the
gardens were overgrown, with bushes and shrubbery not maintained. A large number of weeds were
noted among the paving. The grass was cut on the second day of the inspection. Broken garden furniture
was observed. There was a programme of decorative maintenance, cleaning, decontamination, and repair...
of assistive equipment, but there was no programme of general maintenance. There was a cleaning schedule and the approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with heating controlled from the resident’s own room. 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.

There was a sufficient number of toilets and showers for residents in the approved centre. Wheelchair accessible toilet facilities were identified for use by residents and visitors who required such facilities. The approved centre had a designated sluice room, a designated cleaning room, and a laundry room. The approved centre had a dedicated therapy/examination room that had been completed since the last inspection. All resident bedrooms were appropriately sized to address the resident needs. The approved centre provided assisted devices and/or equipment to address resident needs.

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

a) There was no general programme of maintenance, 22(1)(a).

b) Ligature points had not been minimised to the lowest practicable level and therefore the physical structure had not been maintained with due regard to the safety and well-being of residents, 22(3).

c) The approved centre was not in a good state of repair externally and therefore the condition of the physical structure had not been maintained with due regard to the safety and well-being of residents, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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(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 and protocol in relation to the ordering, storing, prescribing, and administration of medication. The policy had all been last reviewed in July 2019. The policy and protocols 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 policies. All nursing and medical staff as well as pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

Evidence of Implementation: An MPAR was maintained for each resident. Ten MPAR’s were examined and each was found to contain two appropriate resident identifiers, a record of allergies or sensitivities to medications, the generic name of the medication and dedicated space for both routine and once-off medications. The medication records documented the frequency of administration and the dose or amount of the medication to be given. A record of all medications administered to the resident was maintained. A record of all medications that had been withheld by staff or refused by the resident was also present.

The medication prescription record included a clear record of the date of initiation for each medication and a clear record of the date of discontinuation. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was included within the record. All records were legible. Medication for each resident had been reviewed at least six-monthly. All medicines including scheduled controlled drugs were administered by a registered nurse. 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. Good hand hygiene techniques were observed during the dispensing of medications. Medication for the greater part was supplied on a named resident basis in blister packs.
Schedule 2 controlled drugs were checked by two staff members against the delivery form and the controlled drug balance corresponded with the balance recorded in the controlled drug book.

Medication was stored in the appropriate environment as indicated on the label or packaging, and where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication areas were clean and free from damp and mould. Medication storage areas were incorporated into the cleaning and housekeeping schedules. The medication administration cupboard remained locked at all times. A system of stock rotation was implemented to avoid the accumulation of old stock and medications that were no longer required were returned to the pharmacy for disposal.

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 safety statement, dated June 2019 that was adopted as the health and safety policy. The safety statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for raising awareness of residents and their visitors to infection control measures.
- Covering of cuts and abrasions.
- Availability of staff vaccinations and immunisations.
- Management and reporting of an infection outbreak.
- Support provided to staff following exposure to infectious diseases.
- Specific infection control measures in relation to infection types, e.g. C.diff, MRSA, Norovirus.
- First aid response requirements.
- Falls prevention initiatives.

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

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 safety statement 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 and procedures in relation to its staffing requirements. The policy was last reviewed in July 2017. The policy directed the reader to the HSE’s Employee Handbook 2016-2017. The policies and procedures addressed three out of sixteen policy-related requirements of the Judgement Support Framework, including:

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

The policies did not include:

- The roles and responsibilities in relation to staffing processes.
- The job description requirements.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The roles and responsibilities in relation to staff training processes.
- Orientation and induction training for all new staff.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.
**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

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

**Evidence of Implementation:** There was an organisational chart to identify the leadership and management structure as well as the lines of accountability of the approved centre’s staff. A planned and actual staff rota was presented to the inspection team; this showed the staff on duty at any one time during the day and night. The numbers and skill mix of staff were sufficient to meet resident needs. Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment, selection and appointment. All staff were vetted in accordance with the approved centre’s staffing policies. Staff had appropriate qualifications to do their job and an appropriately qualified staff member was on duty and in charge at all times.

The required number of staff on duty at night ensured the safety of residents in the event of a fire or other emergency. Agency staff were used and there was a comprehensive contract between the approved centre and the staffing agency. Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident groups. Orientation and induction training was completed for staff. Not all healthcare professionals who worked in or attend the approved centre were trained in: fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act 2001 as set out in the table below:

<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 (23)</td>
<td>14</td>
<td>60%</td>
<td>16</td>
<td>69%</td>
<td>22</td>
</tr>
<tr>
<td>Medical (5)</td>
<td>3</td>
<td>60%</td>
<td>2</td>
<td>40%</td>
<td>2</td>
</tr>
<tr>
<td>Occupational Therapist (3)</td>
<td>3</td>
<td>100%</td>
<td>1</td>
<td>33%</td>
<td>2</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
</tbody>
</table>

Staff were trained in line with the assessed needs of the resident group profile including: manual handling, infection control and prevention, dementia care and end of life care. All staff training was documented and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff. In-service training was completed by appropriately trained and competent individuals.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.
The following is a table of 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>Cappahard Lodge</td>
<td>CNM 11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0*</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* A HCA was temporarily on night duty at the time of the inspection in response to a special assessed need.

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

- a) Not all healthcare professionals had up-to-date mandatory training in fire safety, Basic Life Support and management of violence and aggression, 26(4).
- b) Not all healthcare professionals had completed mandatory Mental Health Act 2001 training, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the maintenance of records. The local policy was last reviewed in May 2019, and included a statement adopting HSE National policies on record management and retention. The policies and procedures addressed all of the requirements 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. 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: Residents’ records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured and, where possible, were physically stored together.

A record had been initiated for every resident in the approved centre, and these were reflective of residents’ current status and the care and treatment being provided. Resident records were maintained through the use of an identifier that was unique to the resident. Resident records were developed and maintained in a logical sequence and they were accessible to authorised staff only.
Records were written legibly and contained factual, consistent, and accurate entries. Each entry was followed by a signature but not all entries noted the time.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was 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 28: Register of Residents

| COMPLIANT |

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

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

### INSPECTION FINDINGS

The approved centre had an electronic documented register of residents that 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 an addendum dated November 2018 that adopted the HSE’s *National Framework for Developing Policies, Procedures, Protocols and Guidelines* in relation to the development and review of operating policies and procedures required by the regulations. It was dated November 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the development, management, and review of operating policies and procedures.
- The process for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.

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

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed by the Clinical Policy Procedure Protocol Group, which was made up of members of the area management team, including the area director of nursing, principal clinical psychologist, the occupational therapy manager, area lead for mental health engagement, executive clinical director, head of service mental health and administrative staff. There were sub policy groups which included staff representation from the approved centre.

The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Operating policies and procedures were communicated to all relevant staff.

All of the operating policies and procedures required by the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. The format of the policies was standardized but did not include who had approved the policy. Generic policies in use were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre had a written statement to this effect, adopting the policy in question.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and evidence of implementation pillars.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in April 2019 and adopted the HSE Your Service Your Say National Policy dated November 2017.

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

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

**Monitoring:** Audits of the complaints log and related records been completed. Complaints data was analysed.

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

The inspection team were informed that no complaints regarding the approved centre, had been made to the nominated complaints officer for the wider service, through the *Your Service Your Say* process since the last 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 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 suite of policies for risk management. These included the HSE Integrated Risk Management Policy 2017; HSE Incident Management Framework and Guidance 2018; HSE Mid-West Community Health Care Incident Management Procedure, November 2018; Addendum to HSE Integrated Risk Management Policy and Support Guidance 2017; The Incident Management Framework for the Mental Health Division in HSE Mid-West Community Health Care 2018; and the local manual for management of serious incidences and serious reportable events, last reviewed in April 2017. The policies addressed requirements of the Judgement Support Framework, including the following:

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

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy.
**Monitoring:** The risk register had been 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 risk management policy had been implemented throughout the approved centre. Responsibilities were allocated at management level to ensure the effective implementation of risk management. The persons with responsibility for risk was known by all staff in the approved centre. The Quality Patient Safety advisor was also known by all staff. Risk management procedures actively sought to reduce identified risks. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register. Structural risks including ligature points were evident. Associated risk was managed with individual risk assessment, individual care planning and staffing.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, and in conjunction with medication requirements or administration. The multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Due to the resident profile the main risks identified were associated with physical conditions and ailments. A standardised proforma was not used for risk associated with mental health illness. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Incidents in the approved centre were recorded and then inputted into the National Incident Management System (NIMs) by the risk advisor. At the time of the inspection there was no mechanism for the retention of NIMs data within the approved centre. Summary reports were returned to the centre quarterly. This resulted in potential risk adverse material not being readily available to the staff in the approved centre. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission. Information provided was anonymous at resident level. The approved centre had an emergency plan that incorporated fire evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the entrance foyer of the approved centre.</td>
</tr>
</tbody>
</table>

The approved centre was compliant with this regulation.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
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 reviewed annually and was dated September 2018. It addressed the following:

- The provision of information to the resident.
- Who can initiate physical restraint.
- Who may implement physical restraint.

**Training and Education:** There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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

**Evidence of Implementation:** Physical restraint had been used in rare and exceptional circumstances within the approved centre and only after all alternative interventions to manage unsafe behaviour had been considered. The use of physical restraint was based upon risk assessment and cultural awareness and gender sensitivity was demonstrated.

One episode of physical restraint was reviewed as part of the inspection process. The physical restraint had been initiated by a registered nurse. A designated staff member was responsible for leading the physical restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and the registered medical practitioner completed a medical examination of the resident (physical examination) no later than three hours after the start of the episode of restraint. A Clinical Practice Form was completed by the staff member initiating and ordering physical restraint and this form had been signed by the consultant psychiatrist within 24 hours. The resident had been informed of the reasons for, likely duration of and circumstances leading to the discontinuation of physical restraint.

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, which were last reviewed in February 2018.

Admission: The admission policy addressed all of the policy-related criteria for this code of practice. These included a procedure for involuntary admission and protocols for urgent referrals, self-presenting individuals, planned admissions, and timely communication with general practitioners/primary care and community mental health teams.

Transfer: The transfer policy addressed all of the policy-related criteria for this code of practice. These included the procedure for involuntary transfer and the roles and responsibilities of staff in relation to the transfer of residents.

Discharge: The discharge policy addressed all of the policy-related criteria for this code of practice. These included procedures for the discharge of involuntary patients and managing discharge against medical advice and protocols for discharging homeless people and older persons.

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

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

Evidence of Implementation:
One clinical file was inspected in relation to admission. The approved centre had a key worker system in place. The decision to admit was made by the registered medical practitioner (RMP) or consultant psychiatrist. The resident was assessed at admission, and details of all assessments were documented in the clinical file.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents.

Discharge: One clinical file was examined in relation to discharge. The decision to discharge was taken by the RMP. The resident’s individual care plan contained a discharge plan. The resident was comprehensively assessed prior to discharge. The community mental health team/primary care team was informed of the discharge, and a comprehensive discharge summary was issued within 14 days.

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

### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>There was no general programme of maintenance, 22(1)(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>There is now a general programme of maintenance in place for the Approved Centre.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>This programme will be reviewed every 6 months. All staff to be orientated to programme of maintenance with regards to the premises.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Ligature points had not been minimised to the lowest practicable level and therefore the physical structure had not been maintained with due regard to the safety and well-being of residents, 22(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Programme of works identified from bi-annual Ligature Audit, and submitted to Maintenance Department. Some works completed since last inspection. Development works to be progress with Maintenance</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Removal of unnecessary ligatures from communal areas and bedrooms. Bi-annual ligature audit. Staff awareness of all ligature points and findings of audit. All residents reviewed and assessed for risk. (At least 6 monthly as per ICP) Current risk rating is low.</td>
</tr>
</tbody>
</table>

Reason ID : 10000492
The approved centre was not in a good state of repair externally and therefore the condition of the physical structure had not been maintained with due regard to the safety and well-being of residents, 22(3). | Specific | Measurable | Achievable/Realistic | Time-bound | Post-Holder(s) |
Corrective Action | Programme of works identified from walk around of unit. Submitted to Maintenance Department. To be progressed. Further development works to be discussed with Maintenance Department and General Manager. | Identified on Quality Improvement Plan. 3 monthly review. | Realistic | 31/03/2020 | Technical Services; Assistant Director of Nursing; Clinical Nurse Manager II; |
Preventative Action | Funding has been approved for external | Analysis of Maintenance | Achievable | 31/03/2020 | Head of Maintenance |
| painting and works due to commence in coming weeks. Rolling contract arranged with landscaping Company. | programme 6 monthly. |  |  |  |
**Regulation 26: Staffing**

**Reason ID : 10000493**

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

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing training being provided on a monthly basis.</td>
<td>3 monthly audits. Data inputted on training matrix. Review of educational and training needs yearly. Quarterly progress report forwarded to Mental Health Commission.</td>
<td>Realistic</td>
<td>31/03/2020</td>
<td>Assistant Director of Nursing; Clinical Nurse Manager 2;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Continue to provide monthly training sessions locally in mandatory training areas.</td>
<td>3 monthly audit.</td>
<td>Realistic</td>
<td>31/03/2020</td>
<td>Assistant Director of Nursing; Clinical Nurse Manager II</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.