

Carraig Mór Centre

ID Number: AC0018

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Carraig Mór Centre
Shanakiel
Cork

Approved Centre Type:
Psychiatric Intensive Care Unit

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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Inspection Date:
28 – 31 May 2019

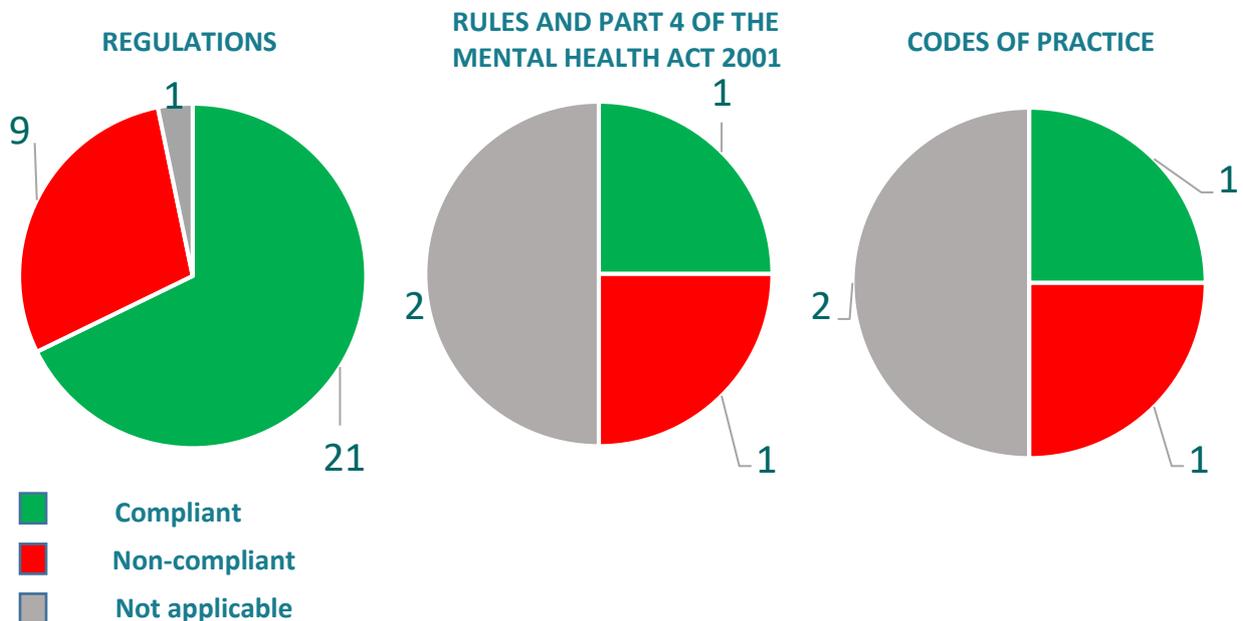
Previous Inspection Date:
9 – 12 October 2019

Inspection Type:
Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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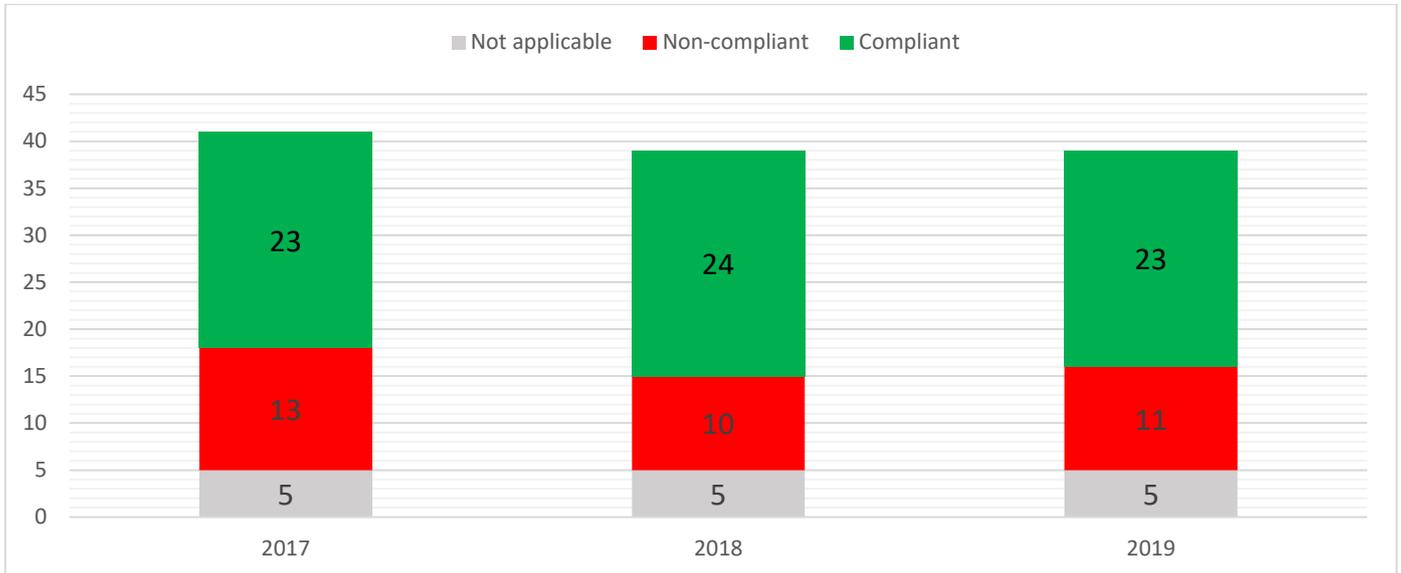
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

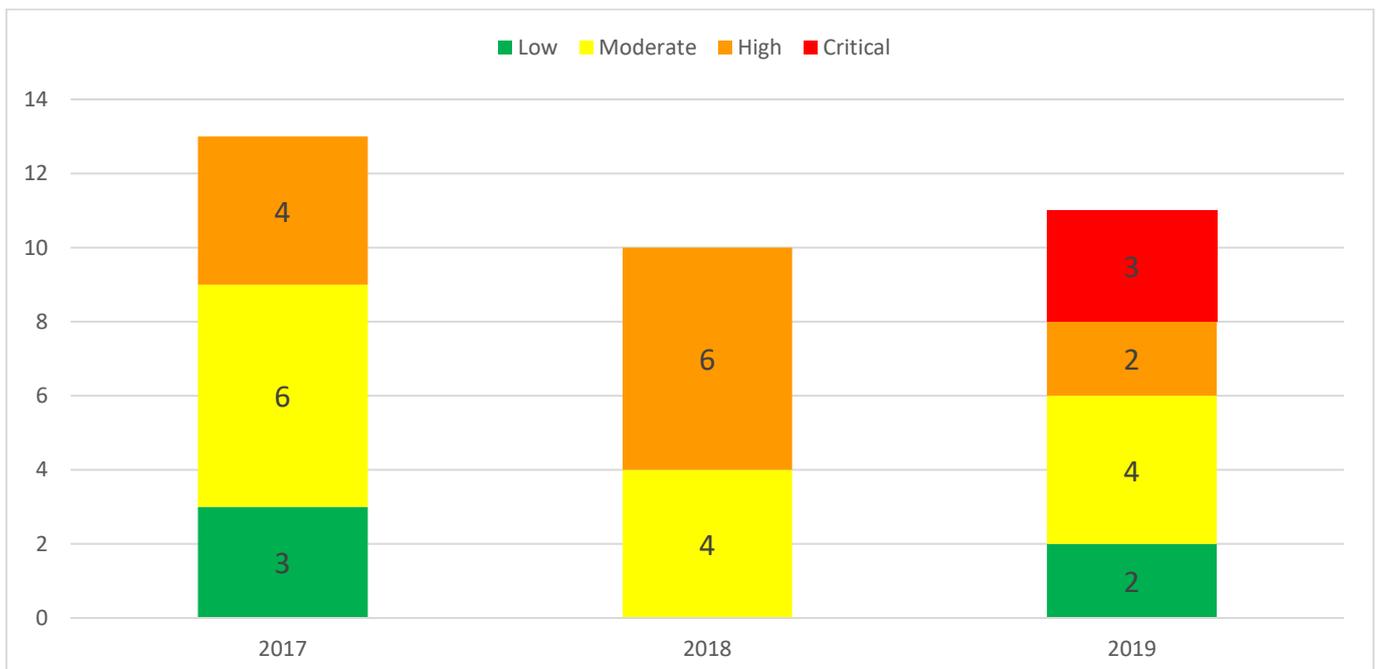
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

Carraig Mór was an 18-bed Psychiatric Intensive Care Unit (PICU) in Shanakiel, Cork. It was a tertiary service with referrals to this service coming from other acute mental health services in Cork, the National Forensic Service and prison services. Accommodation within the dormitories provided residents with limited access to personal space, property storage or privacy. At the time of inspection, there were 11 residents in the male 10-bed dormitory. The clinical teams in Carraig Mór also provided an outreach service to service users in the community.

There has been no improvement in compliance with regulations, rules and codes of practice over a three year period: Compliance was 64% in 2017; 71% in 2018; and 65% in 2019. Eleven compliances with regulations were rated excellent.

Conditions to registration

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

Safety in the approved centre

- Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. Hygiene was maintained to support food safety requirements.
- Medication was ordered, prescribed, stored and administered in a safe manner.

However:

- The process for multi-disciplinary team involvement in the development of individual risk assessments was not very clear, as practices varied amongst staff and, therefore, within residents' clinical files. It is imperative individual risk assessments are robust and standardised as they play an important role in clinical care decision making.
- The corridors were narrow. The shared male and female communal dining room was too small, and space was limited at meal times, when 17 residents and additional staff were in the room. The limited space was a risk due to the potential occurrence of challenging behaviours.
- Hazards were not minimised within the approved centre. The male nursing office was small, provided limited observation, and was hazardous in nature. Several hazards were identified within the

seclusion room. The seclusion room had hard internal walls, the seclusion door opened inwards, and there was a large distance between the seclusion room and the toilet and washing facilities.

- Ligature points were not minimised to the lowest practicable level, based on risk assessment. High risk ligatures were identified in the ligature audit, which took place two months prior to this inspection. These ligature points still remained and were not minimised.
- The approved centre did not have a designated sluice room, which increased the risk of cross infection.
- Not all health care staff were trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001 and Children First.

Appropriate care and treatment of residents

- There was a wide-ranging therapeutic programme which included mindfulness workshops, relaxation, wellness workshops, psychoeducation groups and managing distress workshops. Programmes were developed by two therapy nurses, with significant input from an occupational therapist and a psychologist, and all programmes and services were evidence-based. Adequate and appropriate resources and facilities were available, with a dedicated room which had facilities and space for individual and group therapies.
- Apart from a small number of omissions, each resident had a comprehensive physical examination and physical status monitoring.

However:

- While each resident had an individual care plan (ICP) there were significant deficits:
 - In three ICPs, the goals documented were minimal and did not reflect the needs of the resident.
 - In three ICPs, the interventions documented did not address the care and treatment required to meet the goals identified.
 - In three ICPs, the documentation of resources required were insufficient.
 - In two ICPs, they had not been reviewed and updated by the resident's multi-disciplinary team.
 - In four ICPs, there was no record that ICPs had been reviewed or developed with resident consultation.

Respect for residents' privacy, dignity and autonomy

- Physical restraint was carried out in compliance with the relevant Code of Practice.

- The approved centre was compliant with Part 4 of the Mental Health Act 2001 - Consent to Treatment.
- In general, the approved centre was kept in a good state of repair. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment.

However:

- The male dormitory had 11 beds, which limited residents' personal space and privacy. The number of beds in the male dormitory was reduced to ten during inspection. Two of the beds in the male dormitory did not have a privacy curtain between two of the residents. The beds were close together, with no bedside lockers, wardrobes or chairs. Personal property was kept in shelves above their beds and in small lockable cupboards positioned at the end of the dormitory.
- Residents were facilitated to make and receive phone calls, but not always in a private setting. To make and take phone calls on the ward phone, female residents were handed the landline phone through the hatch of the nurses' office window. Residents then made and took calls within the female dormitory, within earshot of other residents and staff, which was a potential breach of residents' privacy.
- Not all rooms were ventilated. One toilet was not adequately ventilated, within one internal shower room.
- Female residents were not provided with sufficient outdoor space as their access to the garden was limited. The approved centre had one external garden.
- The approved centre was not clean, hygienic, and free from offensive odours. The seclusion room was dirty and malodorous. At the time of the inspection, an undergarment and a night dress were observed behind the seclusion room bed. The seclusion room wall had bodily fluids smeared on the wall. The seclusion room had been used a number of days previously but no cleaning had taken place.
- There was an insufficient number of toilets and showers for residents in the approved centre. The male unit had two unlocked toilets, but only one shower for the single use of all male residents. There was also a locked bathroom on the male side, which contained a bath but no shower, and only one toilet, which was rarely used. The female unit had one shower and a bath. During resident interviews, residents highlighted that the lack of female shower facilities was an issue.
- Seclusion was not carried out in compliance with the Rules Governing the Use of Seclusion resulting in critical risk for residents:
 - The furniture and fittings in the seclusion facility were not of a design and quality as to not endanger patient safety, and residents in seclusion did not have access to adequate toilet and washing facilities. The seclusion facilities were not cleaned and the seclusion room was dirty and malodorous.
 - In one seclusion episode, the resident was not informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. There was no explanation for this documented in the resident's clinical file. In two seclusion episodes, there was no evidence of each resident receiving direct observation by a registered nurse for the first hour and continuous observation thereafter. In two seclusion episodes, the resident was not informed of the ending of the episode of seclusion.

- CCTV monitors in the male and female nursing stations were viewable from the main corridor by members of the public, other residents and staff, including individuals not responsible for the health and welfare of the resident.

Responsiveness to residents' needs

- The approved centre's menus were reviewed by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with menus providing a variety of wholesome and nutritious food choices. Meals were attractively presented in terms of texture, flavour, and appearance.
- The approved centre provided access to recreational activities which included TV, books, board games, jigsaws, colourings, a newspaper group, bingo, jenga, and card games. Discussion groups such as sleep hygiene and mental health awareness ran one day of each weekend on the female ward. There was no Wi-Fi which made watching films difficult. Residents had access to a gym, but were only permitted to use it when escorted by a member of the nursing staff.
- There was a garden on the male ward for male residents but female residents did not have their own garden; instead they had to walk through the male ward to access and use the male ward garden. Female residents could only use the garden area when it was not occupied by male residents and had to be supervised at all times.
- There was excellent written information available for residents about the approved centre, diagnoses and medications.

However:

- The nominated person for complaints did not maintain a record of all complaints relating to the approved centre; minor complaints, investigations and outcomes were not documented. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept separate from the resident's individual care plan.

Governance of the approved centre

- Carraig Mór Psychiatric Intensive Care Unit (PICU) was part of the Cork North Mental Health Services and the wider Cork Kerry Mental Health Community Healthcare Services (Area 4). Carraig Mór was governed by the Carraig Mór Senior Management Team which reported to the Head of Service. The Senior Management Team met monthly.
- A multi-disciplinary approach was fostered within governance structures and clinical care. The various committees' purposes, structures, responsibilities and reporting relationships were well defined. There was a strong sense of camaraderie, flexibility, and cohesion amongst staff to promote quality care.
- The Policy, Procedure, Protocol and Guideline Group provided a multi-disciplinary approach to policy development, review, approval and dissemination. There was an Audit Committee and audits were undertaken by the multi-disciplinary team.

- The approved centre's registered proprietor held overall responsibility for the risk management process. The Risk Register and Incidents Committee monitored and maintained Carraig Mór's risk register on a monthly basis. Carraig Mór's risk register fed into the wider Cork Kerry Mental Health Community Healthcare Services risk register.
- The Area Lead for Mental Health Engagement was a member of the Cork Kerry Mental Health Community Healthcare management meetings. The voice of the service user was sought by Carraig Mór Senior Management Team through opportunities such as the 'Comment, Compliment or Complaint' forms and community meetings held in the approved centre.

However:

- There was an induction programme for new staff; however, not all disciplines documented the induction process formally. Not all disciplines had formal structures and process in place for measuring and encouraging staff's performance planning and personal development. Records indicated not all health professionals had up-to-date mandatory training.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An Animal Assisted Therapy Pilot Programme was initiated in May 2019.
2. A Dietitian commenced quarterly meetings with multi-disciplinary teams and the catering service.
3. A weekend therapy service was initiated; therefore a seven day therapy service was now available for residents.
4. The service implemented a Cork / Kerry Seclusion Management Booklet. The booklet supports staff to follow the Rules Governing the Use of Seclusion.
5. A new vehicle (Skoda Yeti) was available for social and recreational activities.
6. Accommodation for Mental Health Tribunals was enhanced as the room was newly renovated and decorated.
7. Kitchen equipment (cooker, oven and fridge) was installed in the occupational therapy room.
8. The approved centre commenced the development of Best Practice Guidelines for Mental Health Services.
9. A recovery maintenance programme was initiated by nursing staff.
10. The approved centre's patient therapy areas upstairs were newly renovated.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Carraig Mór was an 18-bed Psychiatric Intensive Care Unit (PICU) in Shanakiel, Co. Cork, which opened in 2002. Referrals to this service predominantly came from the following services; St. Michael's Adult Mental Health Unit, Mercy University Hospital, South Lee Adult Mental Health Unit, Cork University Hospital, St. Stephen's Hospital, Glanmire, Centre for Mental Health Care and Recovery, Bantry General Hospital, Central Mental Hospital, Dublin and Cork Prison Services, Cork. The unit comprised of two floors, with residents' accommodation on the ground floor and facilities for activities and therapies on the first floor. The unit consisted of a 10-bed male observation ward, a 5-bed female observation ward, and three female single occupancy rooms. Accommodation within the dormitories provided residents with limited access to personal space, property storage or privacy. At the time of inspection, there were 11 residents in the male 10-bed dorm, 5 residents in the female dorm, and one resident in one of the single occupancy rooms. The entrance door was locked at all times; visitors entering and leaving the building were facilitated by security staff positioned at the main reception. Leading from reception, a locked door led to a visitor's room, a multi-disciplinary team (MDT) meeting room, offices, and subsequently onto the female and male wards.

The male and female sections of the unit were separated by a locked door. The dining room, situated within the male ward, was shared by both male and female residents during meal times. The dining room was compact and was not conducive to facilitating the dining of all 18 residents at once. Both wards had small day rooms and quiet rooms which were bare, due to the fact that they were in the process of being decorated. The service planned for the quiet room to have projectors, a sound system, and bean bags. The nurse's station on both wards sat between the day room and the dormitory bedrooms. The male nurse's station was cramped and hazardous.

There was a large garden, accessible via the male ward. Female residents had limited access to the garden, only while supervised and while the gardens was not being used by male residents. The dormitories, single bedrooms and ward areas were somewhat stark and void of decor. The service reports being restricted in its decorating capability as a result of the resident profile. In an effort to combat this, the service has commissioned a large picture to be designed and placed on the female corridor, with the possibility of the picture being extended throughout the units. In contrast, a modern and stylishly-decorated Mental Health Tribunal room, a gym room and an occupational activity room with a kitchenette are provided on the first floor.

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

Resident Profile	
<i>Number of registered beds</i>	18
Total number of residents	17
Number of detained patients	7
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	8
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Carraig Mór Psychiatric Intensive Care Unit (PICU) was part of the Cork North Mental Health Services and the wider Cork Kerry Mental Health Community Healthcare Services (Area 4). Carraig Mór was governed by the Carraig Mór Senior Management Team which reported to the Head of Service. The Senior Management Team met monthly. Numerous sub-committees and working groups fed into the Carraig Mór Senior Management Team, some of which included the Audit Committee, Policy Committee, Risk Register and Incidents Committee and Consultant Group. There were plans for a Health and Safety Committee to be formulated within the year (2019).

A multi-disciplinary approach was fostered within governance structures and clinical care. The various committees' purposes, structures, responsibilities and reporting relationships were well defined. A bottom-up management style was fostered and was visible within committee structures. This approach appeared to contribute to staff morale, enthusiasm, commitment and increased collaboration. The remit and authority of line managers for the various disciplines was clear. There was a strong sense of camaraderie, flexibility, and cohesion amongst staff to promote quality care. There was an emerging culture of contemporary mental health care practices which clashed with and were hindered by the confined, restrictive, and ill-fitting environment.

There was an induction programme for new staff; however, not all disciplines documented the induction process formally. Not all disciplines had formal structures and process in place for measuring and encouraging staff performance planning and personal development. The availability of clinical supervision varied across disciplines. Annual staff training plans were completed to identify required training; however, records indicated not all health professionals had up-to-date mandatory training. Reportedly, the main barriers for staff not achieving the required mandatory training were the prioritisation of clinical demand over training attendance and the difficulty with ascertaining training places. When feasible, internal trainers and facilitators held training and continuous professional development sessions at night-time in an effort to accommodate night duty staff. Multiple non-mandatory training courses were available to staff and management supported and facilitated higher education programmes in an effort to foster staffs strengths.

The Policy, Procedure, Protocol and Guideline Group provided a multi-disciplinary approach to policy development, review, approval and dissemination. There was an established culture of implementing quality improvement audit tools to monitor and evaluate standards of care. There was an Audit Committee which embraced an auditing schedule and, therefore, the benefits of re-auditing were captured. Audits were

suitably disseminated and undertaken by the multi-disciplinary team. Audit findings were discussed within the Audit Committee and the findings were shared with the relevant governance and committees.

The approved centre's registered proprietor held overall responsibility for the risk management process. The Risk Register and Incidents Committee monitored and maintained Carraig Mór's risk register on a monthly basis. The risk register was also discussed at Senior Management Team meetings when deemed appropriate. Carraig Mór's risk register fed into the wider Cork Kerry Mental Health Community Healthcare Services risk register. All incidents were reviewed by the Risk Register and Incidents Committee. Incident trends and analysis were discussed at the Senior Management Team meetings quarterly. There was a consensus amongst staff that the restrictions of the environment aggravated aggressive incidents and did not facilitate therapeutic de-escalation; however, efforts were made within the confinement of the environment to improve therapeutic space with the planned refurbishment of rooms into male and female quiet rooms.

The risk register did not accurately reflect all the services identified health and safety risks. The process for multi-disciplinary team involvement into the development of individual risk assessments was not very clear, as practices varied amongst staff and, therefore, within residents' clinical files. On occasions risk management plans on individual care plans were insufficiently completed or left blank. It is important individual risk assessments and management plans are robust and standardised as they play an imperative role in clinical care.

The Area Lead for Mental Health Engagement was a member of the Cork Kerry Mental Health Community Healthcare management meetings. The voice of the service user was sought by Carraig Mór Senior Management Team through opportunities such as the 'Comment, Compliment or Complaint' forms and community meetings held in 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:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 15: Individual Care Plan	✓		✓		X	Moderate
Regulation 19: General Health	✓		X	Moderate	X	Low
Regulation 21: Privacy	X	Moderate	X	Moderate	X	Critical
Regulation 22: Premises	X	High	X	High	X	Critical
Regulation 25: Use of Closed Circuit Television	X	High	X	High	X	Moderate
Regulation 26: Staffing	X	Moderate	X	Moderate	X	Moderate
Regulation 27: Maintenance of Records	X	Moderate	X	High	X	High
Regulation 31: Complaints Procedures	✓		✓		X	Low
Regulation 32: Risk Management Procedures	X	Moderate	✓		X	High
Rules Governing the Use of Seclusion	X	High	X	High	X	Critical
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	X	Moderate	X	High	X	Moderate

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents’ Personal Property and Possessions
Regulation 10: Religion
Regulation 13: Searches
Regulation 16: Therapeutic Services and Programs
Regulation 18: Transfer of Residents
Regulation 20: Provision of Information to Residents
Regulation 23: Ordering, Prescribing, Storing, & Administration of Medicines
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children’s Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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

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

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

Three residents spoke with the inspection team over the course of the inspection. Overall, they were complimentary about the staff and the quality of care being provided to them. They were complimentary about the food, and stated they enjoyed the groups and outings facilitated by the approved centre. Residents noted a lack of privacy and autonomy due to the approved centre's environment and individual observational requirements. Male residents in the dormitory bedroom reported they were disturbed at night at times by shouting. Residents commented that the temperature of the water could be temperamental, prone to changing when washing, and also that they had to queue for showers. One resident expressed concern over the lack of access to fresh air and the garden.

Feedback provided to the Irish Advocacy Network by residents, reported that residents were complimentary about staff, the food and appreciated outings. Male residents reported they enjoyed the garden, while in contrast, female residents were frustrated with their lack of access to the garden. There were reports that areas of the ward were dirty. Female and male residents both conveyed feeling "unsafe", "nervous" and "fearful" at times. The Irish Advocacy Network stated residents reported that the doors to the male dormitory were locked at night, which limited their access to communal areas and nursing staff. Some residents reported at these times they feared for their own safety. During the inspection process, resident interviews also indicated that the doors to the male dormitory were locked at night. Staff within the service refuted that this had occurred. Senior management were informed by the inspectors and gave assurances that they would investigate the issue with due diligence, in accordance with local policies.

Three completed resident questionnaires were also returned to the inspectors. One of the questionnaires was completed in full, while the other two were completed in part to various degrees. Two residents (with one of the resident declining to answer the question) documented that when they arrived to the approved centre, a member of staff had explained what was happening in a way that they understood, also stating that they were aware of who their MDT was. Two residents (with one of the resident declining to answer the question) reported not understanding what their individual care plan (ICP) was, but stated they were sometimes involved in setting their own therapeutic goals. One resident (with two residents omitting the questions) reported feeling sometimes safe while on the unit, stating that they felt they would be able to give staff feedback and make a complaint if they were not satisfied with any part of their stay in the approved centre, and stated that they were happy with how staff spoke to them. One resident reported feeling they could communicate freely with family, friends or advocates; one resident reported they could not communicate freely with family, friends or advocates and one resident omitted the question. On a scale of 1 to 10, with 1 being poor and 10 being excellent, one resident completed the scale, rating the approved centre 8 out of 10 for overall experience of care and treatment.

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:

- Executive Clinical Director
- Registered Proprietor Cork and Kerry
- Social Worker Team Leader
- Social Worker
- Head of Mental Health Services Cork and Kerry
- Senior Clinical Psychologist
- Area Administrator
- NCHD
- Staff Nurse x4
- Clinical Nurse Manger II – Carraig Mór
- Clinical Nurse Manger II – FACT
- Therapy / Activities Nurse
- Assistant Director of Nursing
- Acting Community Mental Health Nurse
- Principal Clinical Psychologist
- Senior Occupational Therapist

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation

Regulation 2: Commencement and Regulation

Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating

Excellent

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

INSPECTION FINDINGS

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

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

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

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

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating

Satisfactory

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place on food and nutrition, last reviewed May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Menus were systematically reviewed to ensure that residents were provided with a variety of wholesome and nutritious food, in line with their needs. Documented analysis was completed to improve the food and nutrition processes.

Evidence of Implementation: The approved centre's menus were reviewed by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in the residents' individual care plans. Residents were provided with menus providing a variety of wholesome and nutritious food choices, and hot meals were served daily. Meals were attractively presented in terms of texture, flavour, and appearance.

Both hot and cold drinks were offered to residents regularly. Residents had adequate supplies of safe and fresh drinking water through a supply of 250/500 mls bottled water which was constantly available to residents. The needs of those residents identified as having special nutritional requirements were not reviewed regularly by a dietitian. Once a month, a dietitian spent one day in the approved centre; residents' access to her was on a referral basis only. Nutritional screening was not part of the dietitian's service, and the dietitian had no involvement with multi-disciplinary team meetings. An evidence-based nutritional assessment tool was not being used at the time of the 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 evidence of implementation pillar.

Regulation 6: Food Safety

COMPLIANT

Quality Rating

Excellent

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene, commensurate with their role. Staff training was documented, and evidence of certification was available.

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

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

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. All residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating

Excellent

The registered proprietor shall ensure that:

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in October 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. A record of residents wearing nightclothes during the day, as indicated by their individual care plan, was maintained and monitored.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing such as tracksuits, tops, socks and underwear. The emergency clothing was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised clothing.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating

Excellent

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions, which was last reviewed in October 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 were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

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

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

Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions, including a safe. Female residents had bedside lockers. Male residents had no bedside lockers. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating

Satisfactory

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in February 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 recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities was widely displayed on noticeboards and was updated daily by nurses.

Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Activities included TV, books, board games, jigsaw, colourings, a newspaper group, bingo, jenga, and card games. Discussion groups such as sleep hygiene and mental health awareness ran one day each weekend on the female ward.

Residents' access to watching a film was not straightforward. Staff needed to use their phone connection in order for residents to get access to films, due to the fact that there was no Wi-Fi in the unit. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Residents had access to a gym, but were only permitted to use it when escorted by a member of the nursing staff.

There was a garden on the male ward for male residents. Female residents did not have their own garden, instead having to walk through the male ward to access and use the male ward garden. Female residents could only use the garden area when it was not occupied by male residents and had to be supervised at all times. Communal areas provided were suitable for recreational activities. The approved centre offered access to an activity room, day areas, and an art room. Records of resident attendance at events were maintained in group records or in the clinical files.

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

Regulation 10: Religion

COMPLIANT

Quality Rating

Excellent

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in October 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre. All residents were either of Roman Catholic or Church of Ireland denomination. Residents had access to multi-faith chaplains, if required. Residents had access to local religious services and were supported to attend Mass twice a week, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating

Satisfactory

- (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 operational policy, dated October 2016, and protocols in place in relation to visits. The policy and protocols included all of the requirements of the *Judgement Support Framework*.

Training and Education: All relevant staff had signed a log to indicate that they had read and understood the policy on visits. Relevant staff interviewed could articulate the processes for visits, as set out in the policy.

Monitoring: At the time of the inspection, there were no restrictions on residents' rights to receive visitors. Documented analysis of the processes relating to visits had not been completed.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed. The approved centre had a bright and colourful visitor room to facilitate residents to meet their visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. The visitor's room was recently painted. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times. The facilities available, such as the visiting room which had a supply of children's books, were suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating

Satisfactory

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy, dated May 2017, in relation to resident communication. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy. Staff could articulate the process for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions were monitored on an ongoing basis. Documented analysis was not completed to identify opportunities to improve the communication processes.

Evidence of Implementation: Residents could use mail, fax, and telephone if they desired. Residents had access to a computer, including access to the Internet, under nurses' supervision. Residents had access to the ward phone at any time. The process of risk assessments on residents in relation to any risks associated with residents' external communication was not documented in individual care plans. The clinical director/senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others

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 and evidence of implementation pillars.

Regulation 13: Searches

COMPLIANT

Quality Rating

Excellent

- (1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.
- (2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.
- (3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
- (4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.
- (5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.
- (6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.
- (7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.
- (8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.
- (9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.
- (10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in October 2016 and addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches. The clinical file for one resident who had been searched was inspected. Risk had been assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. The resident's consent was sought and documented, prior to the search taking place.

The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

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

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

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 14: Care of the Dying

COMPLIANT

- (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 two written operational policies in relation to care of the dying, Care of the Dying and Sudden Death and Care of the Dying and Do Not Attempt Resuscitation Orders. The Care of the Dying and Sudden Death policy was last reviewed in October 2016. Care of the Dying and Do Not Attempt Resuscitation Orders policy was last reviewed in August 2016. The policy included the requirements of the *Judgement Support Framework*, with the exception of the process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

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

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

MODERATE

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 monthly basis since 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 reviewed on inspection. Residents were initially assessed at admission and an ICP was completed by the admitting clinician. ICPs were a composite set of documents. ICPs were developed by the MDT following a comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Evidence-based assessments were used where possible.

The ICP did not identify the residents' assessed needs. There was no assessment of recreational or therapy needs. In three ICPs, the goals documented in relation to needs centred around mental state and discharge were minimal, and did not reflect the needs of the resident. Instead, goals were outlined in general language, such as 'to reduce the risk of violence', 'to find suitable accommodation', 'to stabilise mental health', 'maintain good health', and 'accommodation'.

In three ICPs, the interventions documented did not address the needs and goals of the resident; the interventions were documented using terms such as 'monitor compliance', and 'medications and safe environment'. In three ICPs, the resources required to provide the care and treatment were not identified; instead the resources required were stated as 'ward', and 'nursing'.

In two ICPs, a key worker was not identified to ensure continuity in the implementation of a resident's ICP. In four ICPs there was no risk management plan, but, instead there was a statement of risk. In two ICPs, the risk management plan section was blank.

In four ICPs, there was no record that the resident had been informed about their care plan or that they had received a copy of it, or whether they refused a copy. No explanation was given or documented to state why this was the case.

All ICPs inspected detailed a discharge plan for the resident. Not all ICPs were reviewed by the MDT in consultation with the resident on a regular basis. The ICP was updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

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

- a) In three ICPs, the goals documented were minimal and did not reflect the needs of the resident.**
- b) In three ICPs, the interventions documented did not address the care and treatment required to meet the goals identified.**
- c) In three ICPs, the documentation of resources required were insufficient.**
- d) In two ICPs, they had not been reviewed and updated by the resident's multi-disciplinary team.**
- e) In four ICPs, there was no record that ICPs had been reviewed or developed with resident consultation.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating

Excellent

(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 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 therapeutic activities and programmes, as set out in the policy.

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

The team have requested if the following can be inserted "Activity based groups are run and involve task and / or social elements. Task groups are also facilitated to develop skills and are end product and individually orientated

Evidence of Implementation: Therapeutic programmes and services were appropriate to the assessed needs of residents, as documented in their individual care plans. Programmes included mindfulness workshops, relaxation, wellness workshops, psychoeducation groups and managing distress workshops. Activity groups incorporated tasks that enhanced daily living and social skills. Programmes and services were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Programmes and services were developed and implemented by nurse therapy, occupational therapy and psychology. There were plans to include input from the social worker. All programmes and services were evidence-based.

Adequate and appropriate resources and facilities were available, with a dedicated room which had facilities and space for individual and group therapies. Where no internal service existed, an appropriate external service with an approved, qualified health professional was found.

Recreational and therapeutics programmes were displayed on the same daily schedule throughout the approved centre. A record was maintained of participation, engagement, and outcomes achieved through the therapeutic programme in residents' progress notes.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating

Excellent

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre to an emergency department was examined. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This communication included the reasons for transfer, the resident's care and treatment plan, which included the resident's needs, risks, and accompaniment requirements on transfer.

The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident's needs. Communications between the approved centre and receiving facility were documented and followed up by a written referral. Relevant documentation was issued as part of the transfer, with copies retained, including a letter of referral with a list of current medications and a resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the 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

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies in relation to the provision of general health services and the response to medical emergencies, each of which were last reviewed in April 2018. The policies combined included all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

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

Registered medical practitioners assessed the general health needs of residents at admission, and on an ongoing basis as part of the approved centre's provision of care. A general practitioner attended the approved centre every Wednesday to address all residents' general health needs. The non-consultant hospital doctor also attended the approved centre. Residents received appropriate healthcare interventions in line with their individual care plan. Residents' general health needs were monitored and assessed, as indicated by the residents' specific needs, within six months.

The clinical files of five residents who had been cared for in the approved centre for six months or more were assessed. These six-monthly general health assessments included a physical examination, and all required assessments were consistently completed and documented, with one exception: the resident's nutritional status was not assessed and documented in one case.

The five residents on anti-psychotic medication had received an electrocardiogram (ECG) assessment of their heart function and this was documented. Residents on anti-psychotic medication consistently received a documented annual assessment of their glucose regulation and blood lipids. Resident's prolactin levels were not measured and documented in two of the five clinical files inspected.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents' completed general health checks and associated results. Residents had access to national screening programmes according to age and gender including breast check, cervical screening, retina check (for diabetics only), and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre. Residents had access to a smoking cessation programme.

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

- a) **The six-monthly general health assessment was inadequately completed in one case; the resident's nutritional status was not completed and documented, 19(1)(b).**
- b) **Two residents on antipsychotic medication did not receive an annual assessment of their prolactin levels, 19(1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating

Excellent

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents, which was last reviewed in October 2016. 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 policies. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policies.

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

Evidence of Implementation: Residents were provided with a service-user booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs, and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team in the information booklet, and verbally at their initial meeting.

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

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to

the resident, including any possible side effects. Residents had access to interpretation and translation services as required.

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

CRITICAL

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 addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed 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. The general demeanour of staff and the way in which staff addressed and spoke with residents was respectful. 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. Where a resident shared a room the bed screening was inadequate and their privacy was compromised.

The male dormitory had eleven beds, which limited residents' personal space and privacy. The number of beds in the male dormitory was reduced to ten during inspection. Two of the beds in the male dormitory did not have a privacy curtain between two of the residents. This meant that resident's privacy and dignity in bedroom areas was not appropriately respected and maintained at all times. This was rectified during the inspection.

Residents were facilitated to make and receive phone calls, but not always in a private setting. To make and take phone calls on the ward phone, female residents were handed the landline phone through the hatch of the nurses' office window. Residents then made and took calls within the female dormitory, within earshot of other residents and staff, which was a potential breach to residents' privacy.

The approved centre was non-compliant with this regulation because residents' privacy and dignity were compromised due to the following:

- c) Eleven beds were observed within the male dormitory, which limited residents' privacy and dignity.
- d) Two beds in the male dormitory did not have a privacy screen between two of the residents.
- e) Residents were not facilitated to make phone calls in private.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating
Risk Rating

Requires Improvement
CRITICAL

- (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 October 2016. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had not been completed to identify opportunities for improving the premises.

Evidence of Implementation: Due to the resident profile and risk assessment, the main entrance doors to the male and female unit were locked. The approved centre was adequately lit and heated. Appropriate signage and sensory aids were provided to support residents in finding their way around the approved centre. In general, the approved centre was kept in a good state of repair. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained.

Appropriately-sized communal rooms were not provided. Residents in the ten bedded male dormitory did not have access to personal space. There were eleven beds in the ten bedded male dormitory on the first day of inspection, which further limited residents' personal space. The eleventh bed in the male dormitory was removed during the course of inspection. The corridors were narrow. The shared male and female communal dining room was too small, and space was limited at meals times, when seventeen residents and additional staff were in the room. The limited space was a risk due to the potential occurrence of challenging behaviours.

Residents in the male ten bedded dormitory did not have access to adequate furnishings to support their independence and comfort. The beds were close together, separated by curtains, with no bedside lockers, wardrobes or chairs. Personal property was kept in shelves above their beds and in small lockable cupboards positioned at the end of the dormitory. The male dormitory was not suitable sized and furnished to remove excessive noise/acoustics.

Not all rooms were ventilated. One toilet was not adequately ventilated, within one internal shower room. Female residents were not provided with sufficient outdoor space as their access to the garden was limited. The approved centre had one external garden. Residents could only access the garden through a door on the male corridor. As the door to the male corridor was locked, female residents only had limited access to the garden when accompanied by staff. Planned work to the premises was due to take place this year, in August, and will include the re-development of the garden area to include a designated male and female garden.

Hazards were not minimised within the approved centre. The male nursing office was small, provided limited observation and was hazardous in nature. Several hazards were identified within the seclusion room. The seclusion room had hard internal walls, the seclusion door opened inwards and there was a large distance between the seclusion room and the toilet and washing facilities. Ligature points were not minimised, to the lowest practicable level based on risk assessment. High risk ligatures were identified in the ligature audit which took place two months prior to this inspection. These ligature points still remained and were not minimised.

The approved centre was not clean, hygienic, and free from offensive odours. The seclusion room was dirty and malodorous. At the time of the inspection, an undergarment and a night dress were observed behind the seclusion room bed. The seclusion room wall had bodily fluids smeared on the wall. The seclusion room was used for seclusion purposes a number of days prior to this inspection. One toilet in the approved centre was malodorous, due to a lack of ventilation. This meant current national infection control guidelines were not followed. Heating could not be safely controlled in the resident's own room, in compliance with health and safety guidance and building regulations.

There was not a sufficient number of toilets and showers for residents in the approved centre. The male unit had two unlocked toilets, but only one shower for the single use of all male residents. There was also a locked bathroom on the male side, which contained a bath but no shower, and only one toilet, which was rarely used. The female unit had one shower and a bath. During resident interviews, residents highlighted that the lack of female shower facilities was an issue. Toilets were close to day and dining areas. Wheelchair accessible toilet facilities were not identified for use by visitors who require such facilities. There was not at least one assisted toilet per floor. The approved centre did not have a designated sluice room.

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

- a) The residents did not have access to personal space as the male dormitory and communal dining room were not appropriately sized to address the residents' needs, 22(3).**
- b) The male dormitory did not have adequate furnishings to support resident independence and comfort, 22(2).**
- c) There were insufficient number of toilets and showers for residents within the approved centre, 22(3).**
- d) Female residents were not provided with sufficient outdoor space as their access to the garden was limited, 22(3).**
- e) Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**

- f) Hazards relating to the male nursing office were not minimised, 22(3).
- g) Hazards relating to the current design of the seclusion room were not minimised, 22(3).
- h) One toilet was not adequately ventilated, 22(1)(b).
- i) The seclusion room and one toilet were not clean, hygienic and free from offensive odours, 22(1)(a).

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

COMPLIANT

Quality Rating

Excellent

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of the route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's MPAR. A record was kept when medication was refused by the resident.

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

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

Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, were segregated from other medication, and 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

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in June 2018. The policy addressed all the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

- (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
- (b) it shall be clearly labelled and be evident;
- (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
- (d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
- (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in June 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

Evidence Of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. The CCTV cameras used to observe a resident were incapable of recording or storing a resident's image on a tape, disc or hard drive.

CCTV was not used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. The CCTV monitors in the male and female nursing stations were viewable from the main corridor. The observation panel had a blind but this was not used at the inspection time. The existence and usage of CCTV was disclosed to The Mental Health Commission.

The approved centre was non-compliant with this regulation because CCTV monitors in the male and female nursing stations were viewable from the main corridor by members of the public, other residents and staff including individuals not responsible for the health and welfare of the resident, 25(1)(a).

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

MODERATE

(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 policy, dated June 2018, in relation to its staffing requirements. The policy met the requirements of the *Judgement Support Framework*, with the exception of the following:

- The process for transferring responsibility from one staff member to another.
- 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 staff performance and evaluation requirements.
- The evaluation of training programmes.

Training and Education: All relevant staff had signed a document indicating that they had read and understood the staffing 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 number and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis was completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place which identified the leadership and management structure and the lines of authority and accountability of the approved centre's staff. The number 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 procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. An appropriately qualified staff member was on duty at all times. This was documented.

A written staffing plan was not available. Staff were trained in accordance with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan.

Not all health care staff were trained in the following:

- Fire safety.
- Basic Life Support.
- Management of violence and aggression
- The Mental Health Act 2001.
- Children First.

All staff training was documented and staff training logs were maintained. The Mental Health Act 2001 and Mental Health Commission rules and codes and all other Mental Health Commission documentation and guidance were made available to staff throughout the approved centre. Opportunities were made available to staff by the approved centre for further education.

The following is a table of mandatory staff training completion in the approved centre:

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (50)	30	60%	32	64%	49	98%	47	94%	48	96%
Medical (4)	4	100%	4	100%	4	100%	4	100%	4	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%

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

Ward or Unit	Staff Grade	Day	Night
Carraig Mór	ADON	1	On-Call
	Consultant Psychiatrist	1	On -Call
	CNM2	1	1
	RPN	8	8
	Activity Nurse Therapist	1 (9am – 5pm)	
	Occupational Therapist	0.6	
	Social Worker	0.6	
	Psychologist	0.8	

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

- a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, professional management of violence and aggression and Children First, 26(4).
- b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

HIGH

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents' records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use. Resident records inspected were reflective of the residents' status at the time of inspection, and of the care and treatment being provided. Clinical files inspected were not in good order in accordance with national guidelines and legislative requirements. A number of the clinical files inspected contained loose pages.

Resident records were physically stored together. Resident records were maintained using an identifier which was unique to the resident. Only authorised staff made entries in residents' records. Hand-written records were legible, written in black indelible ink, and were readable when photocopied. Not all residents' records included the date and time for each entry, with eleven entries missing the time. Not all entries made by student nurses were countersigned by a registered nurse.

Two appropriate resident identifiers were not recorded on all documentation. Of the clinical files inspected, five pages did not contain enough resident identifiers. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was non-compliant with this regulation because records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, due to the following:

- a) A number of clinical files had loose pages, 27(1).**
- b) Not all residents' records included the time for each entry, 27(1).**
- c) Two appropriate resident identifiers were not recorded on all documentation, 27(1).**
- d) Not all entries made by student nurses were countersigned by a registered nurse, 27(1).**

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating

Excellent

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in June 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

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

The operating policies and procedures required by the regulations were all reviewed within the required three-year timeframe, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines. The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating

Excellent

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in October 2016. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. The tribunal room was off the main unit on the first floor. The tribunal room was bright and spacious, with a large table and chairs. There was a telephone, internet, fax, and photocopier. Staff accompanied and assisted patients to attend their Mental Health Tribunal and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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

Regulation 31: Complaints Procedures

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

LOW

(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 dated October 2016 in relation to the management of complaints. It included the requirements of the *Judgement Support Framework*, with the following exceptions:

- The communication of the complaints policy and procedure with residents, their representatives, family and next of kin, and visitors.
- The documentation of complaints, including the maintenance of a complaints log by the nominated person.

Training and Education: Relevant staff were trained in the complaints management process. All staff had signed the policy log indicating that they had read and understood the policy. All staff could articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: There was no documented evidence that an audit of the complaints log and related records was completed. Complaints data was not analysed.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The overall complaints officer was the area director of nursing, and this was detailed in a notice in each unit. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. Residents were provided with the complaints policy and procedure at admission or soon thereafter. The information was provided within the resident information booklet.

The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint can be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, or the care and treatment of a resident were not adversely affected by reason of the complaint being made.

The nominated person did not maintain a record of all complaints relating to the approved centre; minor complaints, investigations and outcomes were not documented. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept separate from the resident's individual care plan.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure the nominated complaints person maintained a record of all complaints relating to the approved centre; minor complaints were not documented, 31(6).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating

Requires Improvement

Risk Rating

High

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

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

- (a) The identification and assessment of risks throughout the approved centre;
- (b) The precautions in place to control the risks identified;
- (c) The precautions in place to control the following specified risks:
 - (i) resident absent without leave,
 - (ii) suicide and self harm,
 - (iii) assault,
 - (iv) accidental injury to residents or staff;
- (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
- (e) Arrangements for responding to emergencies;
- (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in October 2018. The policy addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- Capacity risks relating to the number of residents in the approved centre.
- Risks to the resident group during the provision of general and care and services.
- Risks to individual residents during the delivery of individualised care.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

Evidence Of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre. Corporate risks and clinical risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Not all health and safety risks were identified, assessed, treated, reported and monitored by the approved centre. The seclusion room was not fit for purpose and hazardous in nature (as outlined under Regulation 22: Premises). The seclusion room was verbally identified as a risk by the service however it was not assessed, recorded, treated, monitored and formally documented as a risk. The health and safety

risk in relation to the male nurse's station was not identified, assessed, recorded, treated, reported, monitored and documented. There was no evidence of a risk assessment form being completed in relation to managing these health and safety risks as per the approved centres policy. Not all health and safety risks were documented in the risk register. The risks associated with the seclusion room and male nurses station were not documented on the risk register at the time of inspection. Structural risks, including ligature points were not effectively mitigated. Ligature works were ongoing at the time of the inspection to remove ligature risks.

Multi-disciplinary teams (MDTs) were not involved in the development, implementation, and review of individual risk management processes. While there was evidence of MDT input into the assessment of individual adverse incidents and within the risk register. The process for multidisciplinary team involvement into the development of individual risk assessments was not very clear, MDT input into individual risk assessments were not consistently documented within the services "First MDT Risk Assessment" form. The individual care plan contained space for a MDT individual risk management plan; however, incomplete or vague risk management plans were documented in a number of cases.

Individual risk assessments were completed prior to episodes of physical restraint and seclusion, at resident admission and transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate, and were implemented as required. Incidents were risk-rated in a standardised format, and were recorded on the national incident management system.

Risk management procedures did not actively reduce risks to the lowest level of risk, as far as was reasonably practicable. A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

- a) The risk management policy did not include all the required elements for the identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre as outlined above under processes, 32(2)(a).**
- b) The approved centre's risk policy was not implemented as there was no risk assessment form completed to assess, record, rate, treat, report, monitor and manage the health and safety risks in relation to the seclusion room and the male nurse's station, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT
Risk Rating **CRITICAL**

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

- (a) a child in respect of whom an order under section 25 is in force, and
- (b) a voluntary patient.

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The policy addressed who may implement seclusion, the provision of information to the resident, and ways of reducing rates of seclusion use.

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

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

Evidence of Implementation: Residents in seclusion did not have access to adequate toilet and washing facilities. There was no toilet across the corridor from the seclusion room. Shower facilities were further away, on a separate corridor through a locked door. The seclusion facilities were not cleaned, and the seclusion room was dirty and malodorous at the time of the inspection. This was a breach to residents' privacy and dignity in seclusion. Undergarments and a night dress were observed behind the seclusion room bed. The seclusion room wall had bodily fluid smeared on the wall. The seclusion room was used for seclusion purposes three days before this inspection. The furniture and fittings in the seclusion facility were not of a design and quality as to not endanger patient safety.

The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame, and this was recorded in the clinical files.

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

In one seclusion episode, the resident was not informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. There was no explanation for this documented in the resident's clinical file. In two seclusion episodes, the residents' next of kin were not informed about seclusion taking place, and the reasons for not informing them was not documented in both clinical files.

In two seclusion episodes, there was no evidence of each resident receiving direct observation for the first hour and continuous observation thereafter, by a registered nurse. In two seclusion episodes, the resident was not informed of the ending of the episode of seclusion. In one seclusion episode, the reason for ending seclusion was not recorded in the clinical file.

All episodes of seclusion were recorded in the resident's clinical file and all uses of seclusion were recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the residents' clinical files, and was available to inspectors.

- a) The furniture and fittings in the seclusion facility were not of a design and quality as to not endanger patient safety, 8.3.
- b) Residents in seclusion did not have access to adequate toilet and washing facilities, 8.1.
- c) The seclusion facilities were not cleaned and the seclusion room was dirty and malodorous, which was a breach to residents' privacy and dignity in seclusion, 8.2.
- d) In one seclusion episode, the resident was not informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. There was no explanation for this documented in the resident's clinical file, 3.6.
- e) In two seclusion episodes, the residents' next of kin were not informed about seclusion taking place, and the reasons for not informing them were not documented in both clinical files, 3.6.
- f) In two seclusion episodes, there was no evidence of each resident receiving direct observation by a registered nurse for the first hour and continuous observation thereafter, 5.1(a).
- g) In two seclusion episodes, the resident was not informed of the ending of the episode of seclusion, 7.3.
- h) In one seclusion episode, the reason for ending seclusion was not recorded in the clinical file, 7.4.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of four involuntary patients based in the approved centre were inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. Two patients were assessed as having diminished capacity to providing consent to treatment and were therefore unable to consent to receiving treatment. Two patients were assessed as being capable of providing consent to receiving treatment, and both provided their consent to treatment.

The clinical files of the two patients who consented to treatment evidenced the following:

- The responsible consultant psychiatrist had undertaken a capacity assessment, which was documented.
- There was a record of the patient’s consent that contained:
 - A written record of the name of specific medications prescribed.
 - Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details were provided of discussions with the patient, including

- The nature and purpose of the medications.
- The effects of medications, including risks and benefits, and views expressed by the patient.
- Any supports provided to the patient in relation to the discussion and their decision-making.

The form 17 contained in each clinical file of the four patients who did not consent to treatment evidenced the following:

- The names of the medication prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of discussions with the patient, including:
 - The nature and purpose of the medications.
 - The effects of the medications, including any risks and benefits.
 - Any views expressed by the patient.
 - Supports provided to the patient in relation to the discussion and their decision-making.
 - Authorisation by a second consultant psychiatrist.

All forms were completed within the appropriate timeframe.

The clinical files of four involuntary patients based in the approved centre were inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment in all cases.

In two cases, the patients were assessed as being capable of providing consent to receiving treatment, and both provided their consent to treatment. In both cases, the detailed consent form contained a written record of the name of specific medications prescribed and confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medications. It also evidenced details of discussions with the patient, including: the nature and purpose of the medications; the effects of medications, including risks and benefits, and views expressed by the patient, and; any supports provided to the patient in relation to the discussion and their decision-making.

In two cases, the patients were unable to consent to the continued receipt of medication and a *Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed in each case. Both forms evidenced the names of the medication prescribed and confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications. Both clinical files included details of discussions with the patients, including; the nature and purpose of the medications; the effects of the medications, including any risks and benefits; any views expressed by the patient, and; supports provided to the patient in relation to the discussion and their decision-making. Authorisation by a second consultant psychiatrist was documented as required in both cases.

All forms were completed within the appropriate timeframe

The approved centre was compliant with Part 4 of the Mental Health Act 2001.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually; and it was last reviewed in September 2018. The policy addressed the following:

- The provision of information to the resident.
- Those who can initiate and implement physical restraint.

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

Monitoring: The approved centre forwarded the relevant annual report to the MHC.

Evidence of Implementation: Three episodes of physical restraint were reviewed on inspection. One resident had been physically restrained twice since the last inspection, and a second resident had been physically restrained once since the last inspection. Physical restraint was only used in rare and exceptional circumstances, when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all three episodes, the restraint order did not last longer than 30 minutes.

Residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. In all cases the resident's next of kin was informed about the physical restraint.

Cultural awareness and gender sensitivity was demonstrated in the three episodes of physical restraint. Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. Both residents discussed the episode with members of the MDT as soon as was practicable. All uses of physical restraint were clearly recorded in the clinical practice forms and detailed and recorded within clinical files.

The approved centre was compliant with this code of practice.

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge: the admission policy was last reviewed in September 2018; the transfer policy was last reviewed in September 2018; and the discharge policy was last reviewed in October 2018. The policies combined included the policy-related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. The resident's admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident's family were involved in the admission process. The resident received an admission assessment, which included the presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan documented the estimated date of discharge, but a reference to early warning signs and relapse and risks were not documented. A discharge meeting was held and was attended by the resident and their key worker, relevant members of the multi-disciplinary team (MDT), and the resident's family. A pre-discharge assessment was completed which addressed the resident's psychiatric and psychological needs, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan.

The resident's current mental state was not examined. Family members were involved in the discharge process. There was appropriate MDT input into discharge planning. A preliminary discharge summary was issued to primary care within three days. A comprehensive discharge summary was issued within 14 days to relevant personnel. The discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

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

- a) The resident's discharge plan did not document early warning signs of relapse and risks, 34.2.
- b) The resident's current mental state was not examined during the pre-discharge assessment, 38.4.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10000759		In three ICPs the goals were minimal and did not reflect the needs of the resident. In three ICPs, the interventions documented did not address the care and treatment required to meet the goals identified. In three ICPs, the documentation of resources required were insufficient. In two ICPs, they had not been reviewed and updated by the resident's multi-disciplinary team. In four ICPs, there was no record that ICPs had been reviewed or developed with resident consultation.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	New prompt sheet developed ICP working group has been established	Through regular audits	Achievable	29/02/2020	All members of the MDT
Preventative Action	Ongoing ICP Training for all staff. Regular spot checks on ICPs with feedback provided at the weekly ICP meetings. A Training log will be maintained	Audits and Training Log	Achievable	29/02/2020	Clinical Director, CNM3 and Clinical Psychologist

Regulation 19: General Health

Reason ID : 1000743		The six-monthly general health assessment was inadequately completed in one case; the resident's nutritional status was not completed and documented, 19(1)(b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Six month general health review dates are scheduled in Ward Diary on admission. Audits will be completed.	Audits of Physical Health Check review dates.	Achievable	31/01/2020	NCHD
Preventative Action	Audits will be completed on physical health check review dates	Through regular audits	achievable	29/02/2020	NCHD
Reason ID : 1000744		Two residents on antipsychotic medication did not receive an annual assessment of their prolactin levels, 19(1)(b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	All individuals prescribed antipsychotics will have prolactin levels complete irrespective of the antipsychotic prescribed.	Prolactin levels will be assessed	achievable	29/02/2020	NCHD
Preventative Action	Physical Health Audit	physical health audit	achievable	29/02/2020	NCHD

Regulation 21: Privacy

Reason ID : 1000764		Residents' privacy and dignity were compromised as eleven beds were observed within the male dormitory, which limited residents' privacy and dignity.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Bed capacity is to be adhered to. A register of residents will be maintained daily for all admissions and discharges.	Register of residents will be maintained	Achievable	31/01/2020	ADON, CNM3 and CNM2
Preventative Action	A register of residents will be maintained daily for all admissions and discharges	Register of residents	Achievable	31/01/2020	ADON, CNM3 and CNM2
Reason ID : 1000765		Residents' privacy and dignity were compromised as two beds in the male dormitory did not have a privacy screen between two of the residents.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A privacy screen is now in place between the two beds	A privacy screen has been put in place between the two beds	Achieved	01/01/2020	ADON
Preventative Action	A privacy screen is now in place	A privacy screen is now in place	achieved	01/01/2020	ADON
Reason ID : 1000766		Residents' privacy and dignity were compromised as residents were not facilitated to make phone calls in private.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Carraig Mor is a PICU therefore a risk assessment will need to be carried out with regard to the use of	The ADON and Area Administrator are liaising with Estates as to the feasibility of exploring alternative	Achievable	31/03/2020	ADON, Area Administrator, Estates

	mobile phones. The service is exploring potential options including hands free phone or a telephone booth so as to facilitate private calls to be made by residents who do not have access to their own phone.	options including a hands free phone or a telephone both.			
Preventative Action	Carraig Mór is a PICU therefore a risk assessment will need to be carried out with regard to the use of mobile phones. The service is exploring potential options including hands free phone or a telephone booth so as to facilitate private calls to be made by residents who do not have access to their own phone.	The ADON and Area Administrator are liaising with Estates as to the feasibility of exploring alternative options including a hands free phone or a telephone both.	Achievable	31/03/2020	ADON, Area Administrator, Estates

Regulation 22: Premises

Reason ID : 10000748		The residents did not have access to personal space as the male dormitory and communal dining room were not appropriately sized to address the residents' needs, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The service is committed to reviewing the current resident accommodation and communal dining area to ascertain if space can be maximised within the existing infrastructure to enhance the resident's needs	Review to be carried out of existing space	Realistic	31/03/2020	Area Administrator and Estates
Preventative Action	Following the findings of the review, the service will determine next steps required with a view to enhancing the residents needs	Dependant on the findings of the review of the existing accommodation and dining area.	Achievable	31/03/2020	Area Administrator and Estates
Reason ID : 10000749		The male dormitory did not have adequate furnishings to support resident independence and comfort, 22(2).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The service will liaise with Estates to address the concerns raised specifically to check feasibility of enclosing a space for	Review of furnishings and explore options with regard to alternative furnishings	Realistic	30/04/2020	Area Administrator, Estates

	residents personal effects				
Preventative Action	Liaise with Estates to explore options with regard to existing or alternative furnishings	Liaise with Estates to explore options with regard to existing or alternative furnishings	Achievable	30/04/2020	Area Administrator, Estates
Reason ID : 10000750		There were insufficient number of toilets and showers for residents within the approved centre, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	As part of the current building plans male toilets and shower areas are being refurbished	Refurbishment of toilets and shower areas	Achievable	31/07/2020	Area Administrator, Estates
Preventative Action	The works will address the concerns relating to the number of toilets available	The works will address the concerns relating to the number of toilets available	Achievable	31/07/2020	Area Administrator, Estates
Reason ID : 10000751		Female residents were not provided with sufficient outdoor space as their access to the garden was limited, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	ADON and Area Administrator to review access for female residents to the outdoor garden space	Review to be conducted to provide female residents with increased access to outdoor garden space	Achievable	31/03/2020	Area Administrator, ADON
Preventative Action	ADON and Area Administrator to review access for female residents to	Review to be conducted to provide female residents with increased access to	Achievable	31/03/2020	Area Administrator, ADON

	the outdoor garden space	outdoor garden space			
Reason ID : 1000752		Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Ligature audit to be completed once Refurbishments and building works have been completed	Ligature Audit	Achievable	30/06/2020	ADON, CNM3
Preventative Action	Ligature inspections completed regularly to review and monitor all potential ligatures- November 2019 & December 2019	Feedback at the monthly management meeting and audit committee meeting	Achievable	31/01/2020	ADON, CNM3
Reason ID : 1000753		Hazards relating to the male nursing office were not minimised, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Male nursing office has now been upgraded. Additionally the old chairs have been removed and replaced with new chairs	Completed	Achieved	31/01/2020	ADON, CNM3 and CNM2
Preventative Action	Male nursing office has now been upgraded. Additionally the old chairs have been removed and	Completed	Achieved	31/01/2020	ADON, CNM3 and CNM2

	replaced with new chairs				
Reason ID : 1000754		Hazards relating to the current design of the seclusion room were not minimised, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Capital plans for funding for a new seclusion room have been approved and tendered	The works will address the concerns raised in relation to the current design	Achievable	30/05/2020	Area Administrator, Estates
Preventative Action	Capital plans for funding for a new seclusion room have been approved and tendered	The works will address the concerns raised in relation to the current design	Achievable	31/05/2020	Area Administrator, Estates
Reason ID : 1000755		One toilet was not adequately ventilated, 22(1)(b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	As part of the current building plans male toilets and shower areas are being refurbished	The works will address the concerns relating to the ventilation of the toilet	Achievable	30/06/2020	Area Administrator, Estates
Preventative Action	As part of the current building plans male toilets and shower areas are being refurbished	The works will address the concerns relating to the ventilation of the toilet	Achievable	30/06/2020	Area Administrator, Estates
Reason ID : 1000756		The seclusion room and one toilet were not clean, hygienic and free from offensive odours, 22(1)(a).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	CNM3 to conduct a walk through with housekeeping	Weekly walk through with housekeeping	Achievable	31/01/2020	ADON, CNM3

	weekly. Booklet on hygiene.				
Preventative Action	CNM3 to conduct a walk throguh with housekeeping weekly. Booklet on hygiene.	Weekly walk through with housekeeping	Achievable	31/01/2020	CNM3 and Housekeeping

Regulation 25: Use of Closed Circuit Television

Reason ID : 10000732		The CCTV monitors in the male and female nursing stations were viewable from the main corridor by members of the public, other residents and staff including individuals not responsible for the health and welfare of the resident, 25(1)(a).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A weekly walk through the unit to ensure that the CCTV Monitors in nursing stations are not viewable from main corridor. Ensuring that the Forest Screen which is in place on the windows is intact and not damaged and the CCTV monitors are positioned correctly	A walk through checklist will be completed	Achievable	29/02/2020	ADON, CNM3 and CNM2
Preventative Action	The Forest Screen which is in place on the windows is intact and not damaged. Ensuring that the CCTV monitor is positioned correctly	Checklist will be completed following the walk through	Achievable	29/02/2020	ADON, CNM3 and CNM2

Regulation 26: Staffing

Reason ID : 10000757

Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, professional management of violence and aggression and Children First, 26(4). Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	2 fire training sessions have been scheduled for onsite training in January and off site training can also be availed of throughout the year New BSL trainer now in post and will train offsite and on site PMAV dates are available frequently Staff have been informed that no further leave for training/education is permitted until mandatory training has been completed and is up to date.	Regular Audits. Training Statistics are a standing agenda item on the monthly management meeting	Achievable	29/02/2020	Heads of Discipline
Preventative Action	Training plans are to be reviewed at the monthly management meetings	Discussion at the monthly management meetings	Achievable	29/02/2020	Heads of Discipline

Regulation 27: Maintenance of Records

Reason ID : 10000767		Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, due to a number of clinical files had loose pages, 27(1). Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, as not all residents' records included the time for each entry, 27(1). Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval as not all entries made by student nurses were countersigned by a registered nurse, 27(1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	4 Training sessions secured for all staff in relation to volumising of clinical files. Regular spot checks on the Maintenance of the clinical files Staff have been instructed to completed HSEland training module on healthcare records	Regular spot checks and audits	Achievable	30/04/2020	All line managers
Preventative Action	Regular audits& spot checks-feedback at the Monthly Management meeting or/ and as required to all line Managers Training Log maintained and is a standing item on monthly management meeting	Training log will be maintained and discussed at the monthly management meetings.	Achievable	30/04/2020	All line managers

Regulation 31: Complaints Procedures

Reason ID : 1000747		The registered proprietor did not ensure the nominated person maintained a record of all complaints relating to the approved centre; minor complaints as minor complaints were not documented, 31(6).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Minor complaints log to be stored in Male and female nursing offices.	Complaints, comments and Compliments to be to be placed as a standing items on the agenda of the monthly management meeting	Achievable	29/02/2020	Area Administrator, ADON and CNM3
Preventative Action	Quarterly Survey for clients will be distributed providing feedback for catering. Fortnightly community group is facilitated by nursing staff for clients to voice any concerns/complaints YSYS boxes and leaflets are available throughout the unit	Nutritional Steering committee will meet regularly present client feedback Community meeting feedback is a standing item on the Monthly Management meeting YSYS boxes are checked regularly by CNM2s	Achievable	31/03/2020	Catering Officer, CNM2's and RPNs

Regulation 32: Risk Management Procedures

Reason ID : 10000745		The risk management policy did not include all the required elements for the identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre, 32,(2)(a).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Amendments made to the existing Risk Management Policy	Risk Management Policy has been amended	Achievable	29/02/2020	ECD, ADON, CNM3 and RPN
Preventative Action	Review at Policy Committee meeting and update Regulation 32 Audit Tool to reflect changes to Risk Management Policy	Review at Policy Committee Meetings	Achievable	29/02/2020	ECD, ADON, CNM3 and RPN
Reason ID : 10000746		The approved centres risk policy was not implemented as there was no risk assessment form completed to assess, record, rate, treat, report, monitor and manage the health and safety risks in relation to the seclusion room and the male nurse's station, 32(1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Male nursing office has now been upgraded. Additionally the old chairs have been removed and replaced by new chairs. Plans for new seclusion suite complete with funding approved.	Existing Seclusion Room is currently on the risk register and is reviewed monthly at Incident and Risk Review meeting	Achievable	31/03/2020	Area Administrator and ADON
Preventative Action	There is a limited amount of chairs in the male office at all times to reduce any	Review of all incidents at monthly Incident and Risk Review meeting	Achievable	31/05/2020	Area Administrator and ADON

	potential risks of injury to staff or clients. Estimate plans for new seclusion room are anticipated to be completed in May 2020				

Rules Governing the Use of Seclusion

Reason ID : 10000735		The furniture and fittings in the seclusion facility were not of a design and quality as to not endanger patient safety, 8.3. Residents in seclusion did not have access to adequate toilet and washing facilities, 8.1.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A seclusion booklet is now in place. Capital plans in relation to new seclusion room funding has been approved and tendered.	Regular audits will be carried out	Achievable	31/03/2020	Area Administrator, Estates
Preventative Action	A seclusion booklet is now in place. Capital plans in relation to new seclusion room funding has been approved and tendered.	Regular Audits will be carried out	Achievable	31/03/2020	Area Administrator, Estates
Reason ID : 10000738		In one seclusion episode, the resident was not informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. There was no explanation for this documented in the resident's clinical file, 3.6. In two seclusion episodes, the residents' next of kin were not informed about seclusion taking place, and the reasons for not informing them were not documented in both clinical files, 3.6. In two seclusion episodes, the resident was not informed of the ending of the episode of seclusion, 7.3. In one seclusion episode, the reason for ending seclusion was not recorded in the clinical file, 7.4.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The Seclusion Management Booklet had just been introduced at last inspection and is now	The audit which was completed in January demonstrated that these points have been addressed.	Achieved	31/01/2020	ECD

	used for all episodes of seclusion, The Seclusion Management Booklet covers all these points.				
Preventative Action	This will be reaudited in 3 months time and regularly thereafter	Through audits	achievable	30/04/2020	ECD, ADON,
Reason ID : 10000740		In two seclusion episodes, there was no evidence of each resident receiving direct observation by a registered nurse for the first hour and continuous observation thereafter, 5.1(a).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The Seclusion Management Booklet had just been introduced at last inspection and is now used for all episodes of seclusion, The Seclusion Management Booklet covers all these points.	The audit which was completed in January demonstrated that these points were being addressed	Achieved	31/01/2020	ECD
Preventative Action	Reaudit in 3 months	Audit in 3 months	Achievable	30/04/2020	ECD, ADON

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 1000733		The resident's discharge plan did not document early warning signs of relapse and risks, 34.2.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	New Discharge Template is in place.	Through the introduction of a new discharge template	Achievable	01/02/2020	Clinical Director
Preventative Action	To comply with Best Practice a checklist will be completed for Discharge Planning	Through regular audits of the checklist	Achievable	31/03/2020	Clinical Director and ADON
Reason ID : 1000734		The resident's current mental state was not examined during the pre-discharge assessment, 38.4.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A new discharge template has been introduced	Through the introduction of a new discharge template	Achievable	01/02/2020	Clinical Director and ADON
Preventative Action	To comply with Best Practice, a checklist will be completed for discharge planning. Audit findings will be discussed at the Audit Committee Meeting	Feedback at the Audit Committee Meetings	Achievable	29/02/2020	Clinical Director and ADON

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.

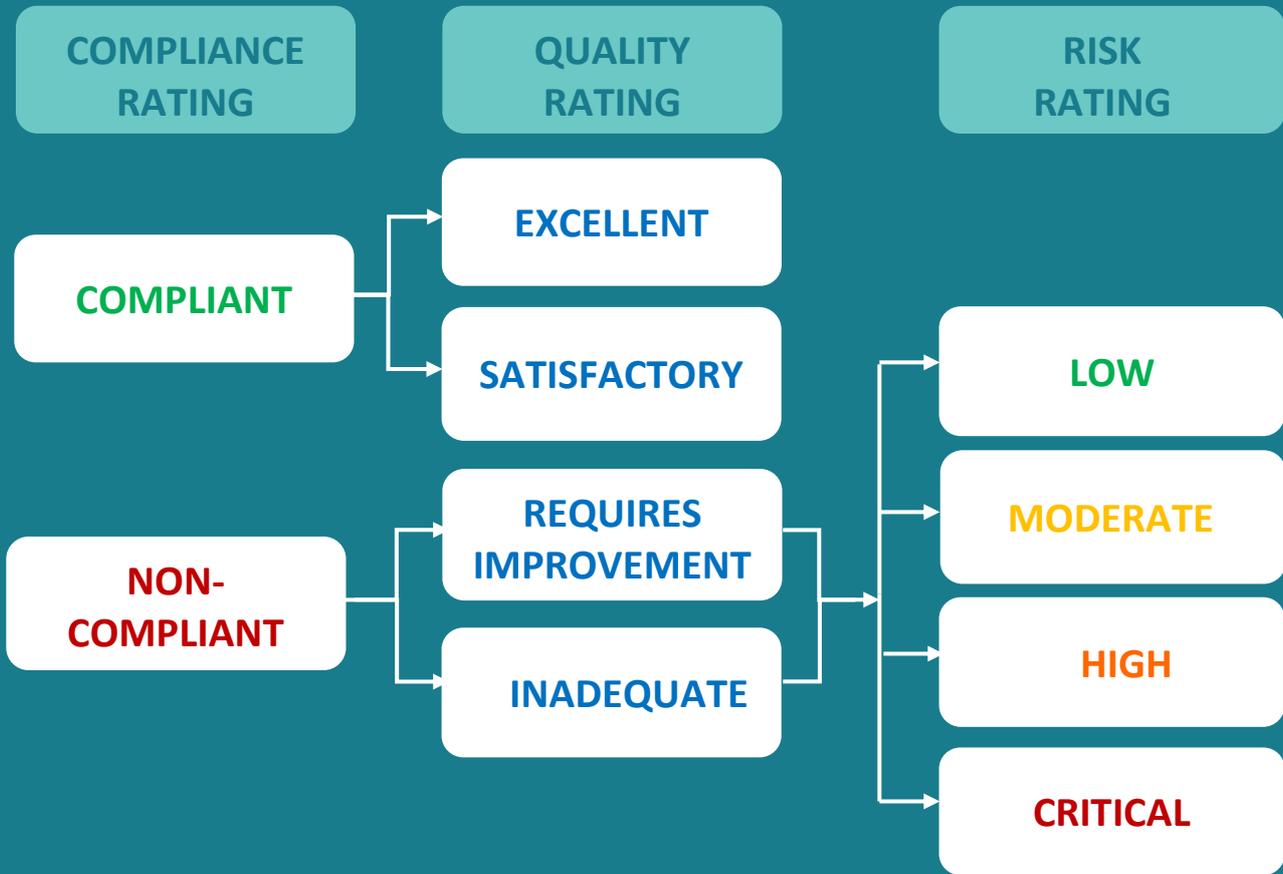
COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.

QUALITY RATINGS are generally given for all regulations, except for 28, 33 and 34.

RISK RATINGS are given for any area that is deemed non-compliant.



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.

