Creagh Suite, St Brigid's Healthcare Campus

ID Number: AC0100

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Creagh Suite, St Brigid's Healthcare Campus
Creagh
Ballinasloe
Co Galway

Conditions Attached:
None

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

Most Recent Registration Date:
3 October 2016

Registered Proprietor:
HSE

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

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Martin McMenamin
Marianne Griffiths

Inspection Date:
5 – 8 March 2019

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
6 – 9 March 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 29 August 2019

2019 COMPLIANCE RATINGS

REGULATIONS
1
2
Compliant
Non-compliant
Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH
1
2
3

CODES OF PRACTICE
2
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**
Contents

1.0 Inspector of Mental Health Services – Review of Findings ................................................................. 4

2.0 Quality Initiatives ........................................................................................................................................ 7

3.0 Overview of the Approved Centre ........................................................................................................... 8
   3.1 Description of approved centre ............................................................................................................ 8
   3.2 Governance ........................................................................................................................................... 8
   3.3 Reporting on the National Clinical Guidelines .................................................................................... 9

4.0 Compliance ................................................................................................................................................ 10
   4.1 Non-compliant areas on this inspection ............................................................................................. 10
   4.2 Areas of compliance rated “excellent” on this inspection ................................................................. 10
   4.3 Areas that were not applicable on this inspection ............................................................................... 11

5.0 Service-user Experience .......................................................................................................................... 12

6.0 Feedback Meeting ..................................................................................................................................... 13

7.0 Inspection Findings – Regulations ........................................................................................................... 14

8.0 Inspection Findings – Rules .................................................................................................................... 51

9.0 Inspection Findings – Mental Health Act 2001 ...................................................................................... 53

10.0 Inspection Findings – Codes of Practice ............................................................................................... 54

Appendix 1: Corrective and Preventative Action Plan .................................................................................. 57

Appendix 2: Background to the inspection process ..................................................................................... 58
1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The approved centre was on the grounds of St. Brigid’s Hospital, Ballinasloe. The Creagh Suite was located on the ground floor within the eastern half of a 1930s limestone building. The approved centre was registered for 14 beds. At the time of inspection, there were nine residents in the unit. The approved centre was a long-stay, continuing-care facility for residents living with dementia and experiencing psychological and behavioural symptoms of that illness. Two single en suite bedrooms were for the assessment of residents upon admission and the remaining beds were allocated to psychiatry of later life residents.

There was excellent overall compliance with regulations, rules and codes of practice at 97%, an improvement from 73% in 2018. There were 14 compliances with regulations that were rated excellent, including Regulation 15: Individual Care Plan, Regulation 20: Provision of Information and Regulation 21: Privacy. The enthusiasm and commitment to delivering a quality service was evident.

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

- The approved centre had made good progress in staff training in Basic Life Support, fire safety, prevention and management of aggression and violence and the Mental Health Act 2001.
- Medication management was excellent.
- The premises was free from hazards, and risks from ligature anchor points were minimised.
- Food safety procedures were excellent.

Appropriate care and treatment of residents

- Each resident had an individual care plan (ICP) that contained assessed needs, goals, interventions, resources and regular reviews. Each care plan was multi-disciplinary and where possible involved the resident and their families. Therapeutic services and programmes provided by the approved centre
were evidence-based, reflective of good practice guidelines and met the assessed needs of the residents, as documented in the residents’ ICPs.

- Adequate resources and facilities were available. Therapeutic services and programmes were provided in separate dedicated rooms, with facilities to carry out group programmes or one to one sessions. Activities included hand massage, dance therapy, art therapy, life story work, one to one social work, psychology, occupational therapy, medical, and nursing. Chiropody, podiatry, speech and language therapy, and dietetics were provided also. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.
- Residents received appropriate general health care interventions in line with their ICPs and each of the five clinical files inspected evidenced that all residents had received a six-monthly general health assessment. For residents on antipsychotic medication, they received an annual assessment on glucose regulation, blood lipids, prolactin levels, and electrocardiogram. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required.

Respect for residents’ privacy, dignity and autonomy

- Resident bedrooms were personalised, and they were clean and bright. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque plastic. Noticeboards did not display any identifiable resident information.
- The approved centre was clean and well maintained.
- Mechanical restraint was only used when each resident posed an enduring risk of harm to themselves or to others or to address a clinical need, and it was only used when less restrictive alternatives were not suitable. Its use was compliant with the Rules Governing the Use of Seclusion and Mechanical Restraint.

Human Rights

There were no breaches of human rights evident in the approved centre at the time of inspection.

Responsiveness to residents’ needs

- There was a spacious and well-equipped dining room which was also used for recreational and therapy activities. There was a multi-sensory room for residents and a conservatory-style day room opposite the dining room. Residents in the approved centre had access to a secure, dementia friendly garden.
- Appropriate information was provided for residents and their families and there was a robust complaints procedure in place. Visiting time was flexible and there were private spaces for receiving visitors.
• Residents were provided with a variety of wholesome and nutritious food. Residents had at least two choices for meals, and hot meals were served daily. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

Governance of the approved centre

• The approved centre was a part of the HSE’s Community Healthcare Organisation (CHO) 2 area. The governance structure encompassed the wider Galway/Roscommon Mental Health Service.
• The Area Management Team met monthly and issues such as service performance, health and safety, risk register, complaints, policies, patient safety and service-user engagement were discussed at these meetings, which evidenced a robust and active agenda with outcomes and actions allocated accordingly.
• The clinical governance mental health team met every month with input from all relevant heads of discipline. A number of subgroups fed into the clinical governance meeting and these included the Health and Safety Subgroup, Drugs and Therapeutic Subgroup, Policies and Procedures Subgroup, Audit and Quality Improvement Subgroup, and Quality and Safety Committee, which included the Risk Management Subgroup.
• The Quality and Safety Committee meeting was scheduled monthly. Creagh Suite business meetings took place monthly and indicated a strong commitment to the health and wellbeing of the resident profile and continuous improvement of service delivery, particularly with regard to person-centred care.
• The Heads of Discipline outlined regular engagement with staff and they outlined clear lines of responsibility. The retention of staff was identified during interview and within the returned governance questionnaires, as a key operational risk for the approved centre.
• There was active risk management and implementation of risk policies.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had introduced an ethical decision making framework with regard to end of life care.

2. Personal evacuation emergency plans (PEEPs) had been implemented to ensure resident safety.

3. The approved centre had introduced Safety Pause meetings. Safety Pause supports healthcare teams in increasing awareness and focusing on patient safety while providing quality safe care.

4. The approved centre continued to develop residents’ life storybooks as part of their person-centred approach to care. Creagh Suite recently had won a HSE staff recognition award for this project.

5. There was new artwork (paintings and murals) on the walls on the corridors of the approved centre to improve the home like environment and stimulate resident’s memories.

6. TV monitors had been introduced to show short information sessions for staff and residents and tips for family members.

7. The approved centre had surveyed residents’ families with regard to their satisfaction with the unit. Surveys were awaiting collation.

8. The approved centre had purchased iPads which when fully functioning will include residents’ care and treatment and life stories for each of the residents.
3.1 Description of approved centre

The approved centre was on the grounds of St. Brigid’s Hospital, Ballinasloe. The Creagh Suite was located on the ground floor within the eastern half of a 1930s limestone building, and was formerly known as St. Dymphna’s ward. It occupied the same building as the St Brigid’s Education Centre which facilitated courses run by the Centre of Nursing and Midwifery Education. The approved centre was registered for 14 beds. At the time of inspection, there were nine residents in the unit. The approved centre was a long-stay, continuing-care facility for residents living with dementia and experiencing psychological and behavioural symptoms. Two single en suite bedrooms were for the assessment of residents upon admission and the remaining beds were allocated to psychiatry of later life residents.

Accommodation for residents comprised two three-bedded rooms, two double rooms and four single rooms. Resident bedrooms were personalised, and they were clean and bright. There was a spacious and well-equipped dining room which was also used for recreational and therapy activities. There was a multi-sensory room for residents and a conservatory-style day room opposite the dining room. Residents in the approved centre had access to a secure, dementia friendly garden.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>14</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>9</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>9</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was a part of the HSE’s Community Healthcare Organisation (CHO) 2 area. The governance structure encompassed the wider Galway/Roscommon Mental Health Service.

The Area Management Team met monthly and the minutes from these meetings were provided to the inspection team. Issues such as service performance, health and safety, risk register, complaints, policies, patient safety and service-user engagement were discussed at these meetings, which evidenced a robust and active agenda with outcomes and actions allocated accordingly.

The clinical governance mental health team met every month with input from all relevant heads of discipline. A number of subgroups fed into the clinical governance meeting and these included the Health and Safety
Subgroup, Drugs and Therapeutic Subgroup, Policies and Procedures Subgroup, Audit and Quality Improvement Subgroup, and Quality and Safety Committee, which included the Risk Management Subgroup.

The Quality and Safety Committee meeting was scheduled monthly and the minutes of meetings held since the last inspection were presented to the inspection team. The risk register and incidents were reviewed at this meeting. Clinical auditing, quality improvement plans, and the report from the Policy, Procedure and Protocol Guideline Committee were also discussed at this meeting.

Creagh Suite business meetings took place monthly. The minutes for the previous meeting were provided to the inspection team and the minutes demonstrated an agenda that was specific to the approved centre. This indicated a strong commitment to the health and wellbeing of the resident profile and continuous improvement of service delivery, particularly with regard to person-centred care.

The inspection team sought to meet with heads of discipline during the inspection, and they interviewed the following:

- Clinical Director
- Principal Social Worker
- Area Director of Nursing
- Occupational Therapy Manager
- Area lead for mental health engagement

The Heads of Disciplines outlined regular engagement with staff and they outlined clear lines of responsibility. The retention of staff was identified during interview and within the returned governance questionnaires, as a key operational risk for the approved centre.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

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

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team endeavoured to engage with residents and their relatives 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 and families to talk to the inspection team.
- Set times and a private room were available to talk to residents and their relatives.
- 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.

Due to the resident profile, inspectors were unable to meet with the residents to get feedback. The inspection team did not receive any completed service user experience questionnaires. Questionnaires were left in the approved centre should relatives wish to complete them and return them to the Mental Health Commission.
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:

- Assistant Director of Nursing
- CNM3 x 2
- Clinical Director
- General Manager
- Senior Social Worker and representing Principal Social Worker
- Area Director of Nursing

Apologies were received on behalf of the Area Lead for Mental Health Engagement and the Occupational Therapy Manager.

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Clarifications were provided to the inspectors by the approved centre staff in relation to the resident profile and associated risks. Minutes of business meetings were to be forwarded to the inspection team.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The approved centre used identity wristbands, and photograph to identify residents. The preferred person-specific identifiers used were appropriate to the residents’ communication abilities, and were detailed within residents’ clinical files. The identifiers were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used to help staff in distinguishing between residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Irish Food Pyramid. Residents had at least two choices for meals, and hot meals were served daily. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot and cold drinks were offered to residents regularly.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in 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 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. Training was documented and evidence of certification was available.

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Catering services had appropriate hand-washing areas.

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

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

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

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

**Monitoring:** The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. No current residents were prescribed to wear nightclothes during the day.

**Evidence of Implementation:** Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the 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. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff and the resident or their representative.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in October 2017. The policy included the requirements of the Judgement Support Framework with the exception of the facilities available for recreational activities, including the identification of suitable locations for recreational activities within and external to the approved centre.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident 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. The resident information booklet given to residents, detailed accessible and user-friendly information on recreational activities, including the type and frequency of recreational activities. Activities included beauty care, hand massage, music, and the life story book. Residents had access to an outdoor garden area in good weather conditions. Residents’ ideas were considered and integrated into recreational programmes. Events and resident interests were identified from life story work with each resident, and were incorporated into the content of recreational programmes where appropriate and where possible.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
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. The policy was last reviewed in November 2016. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- Facilitating residents in the practice of their religion, insofar as is practicable.
- Respecting religious beliefs during the provision of services, care, and treatment.

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. While all residents were of Roman Catholic denomination, multi-faith chaplains were available if required. There were facilities available to support residents’ religious practices, including an inter-faith chapel. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: There had been no restrictions on resident communication since the last inspection. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents could use a portable cordless telephone, and receive and send post if they wished. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan.

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

**Regulation 13: Searches**

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

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

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

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

There were no searches conducted in the approved centre since the last inspection, therefore the approved centre was assessed under the two pillars of processes and training and education only.

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

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

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

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

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

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

INSPECTION FINDINGS

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

There were no deaths in the approve centre since the last inspection, monitoring and evidence of implementation pillars were not applicable, and were not assessed.

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Each resident had an Individual Care Plan (ICP), nine of which were inspected. A key worker was identified to ensure continuity in the implementation of a resident’s ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Residents had been assessed at admission by the admitting clinician and an ‘initial’ ICP was completed by the admitting clinician to address the immediate needs of the resident. All residents received an evidenced-based 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, and next of kin, as appropriate.

The ICPs identified the resident’s assessed needs, appropriate goals, and the care and treatment required to meet the identified goals, including the frequency and staff responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan. All nine ICPs inspected had a preliminary discharge plan documented.

The ICP was reviewed by the MDT in consultation with the resident regularly. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 16: Therapeutic Services and Programmes

<table>
<thead>
<tr>
<th>COMPLIANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Rating</td>
</tr>
</tbody>
</table>

(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 May 2018. The policy included all of the requirements of the [Judgement Support Framework](#).

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

**Monitoring:** The range of services and programmes provided in the approved centre were not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

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

Adequate resources and facilities were available. Therapeutic services and programmes were provided in separate dedicated rooms, with facilities to carry out group programmes or one to one sessions. Most therapeutic services were provided on a one to one basis with the resident. Activities included hand massage, dance therapy, art therapy, life story work, one to one social work, psychology, occupational therapy, medical, and nursing. Chiropody, podiatry, speech and language therapy, and dietetics were provided also. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: 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 patient (a ward of court), 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 emergency transfer was documented. This was followed up by a written referral. Documented records included the reasons for transfer, the patient’s care and treatment plan, including needs and risks, and the patient’s accompaniment requirements on transfer. A patient passport was available for this resident.

The patient was risk assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident’s needs. The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, an implementation checklist, and the 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 patient’s clinical file.

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

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The medical emergency policy was last reviewed in August 2018. The policy included 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 the provision of general health services and the response to medical emergencies, as set out in the policy.

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

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, and each of the five clinical files inspected evidenced that all residents had received a six-monthly general health assessment.

For residents on antipsychotic medication, they received an annual assessment on glucose regulation, blood lipids, prolactin levels, and electrocardiogram. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes appropriate to age and gender. Residents had access to information on national screening programmes, which was displayed on noticeboards and in the approved centre’s information brochure. Residents had access to smoking-cessation programmes and supports within the approved centre, but at the time of the inspection, none of the residents were smokers.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

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

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

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

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

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 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 the resident 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

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 April 2017. The policy addressed all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the 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: There were nine residents in the approved centre, and most residents were in single bedrooms. Two residents shared a 3-bed room, and one resident had a 3-bed room to him/herself. The way in which staff spoke with residents was respectful. Staff were discreet when discussing the resident’s condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity. Staff wore uniforms.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, and locks had an override function. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque plastic. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

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

- The approved centre’s utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The identification of hazards and ligature points in the premises.

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

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

Evidence Of Implementation: The approved centre was adequately lit, heated, and ventilated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. All resident bedrooms were appropriately sized to address the resident needs. There was sufficient space for residents to move about, including outdoor spaces. There was a sufficient number of toilets and showers for residents in the approved centre. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised throughout the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Where faults or problems were identified in relation to the premises, this was communicated...
through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Backup power was available to the approved centre.

The approved centre had a designated sluice room and a designated cleaning room. The approved centre provided assisted devices and equipment including hoists, slings and mobility equipment to address resident needs. Remote or isolated areas of the approved centre were monitored.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
**Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines**

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


**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in April 2018. The policies included all of the requirements of the *Judgement Support Framework*.

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

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

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

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

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 fridges were kept locked. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge 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, 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

(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 in relation to the health and safety of residents, staff, and visitors, which was last reviewed in November 2018. The policy addressed all the requirements of the Judgement Support Framework.

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

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

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

The approved centre was compliant with this regulation.
Regulation 25: Use of Closed Circuit Television

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in April 2018. The policy addressed requirements of the Judgement Support Framework with the exception of the maintenance of CCTV cameras by the approved centre.

Training and Education: Relevant staff had signed 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: CCTV was recently installed in the approved centre, and the quality of the CCTV images were checked regularly to ensure that the equipment was operating appropriately.

Evidence Of Implementation: There were clear signs in prominent positions where CCTV cameras were located. There were two CCTV cameras used to monitor the outside garden area. 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 used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. The Mental Health Commission had been informed about the approved centre’s use of CCTV.

The approved centre was compliant with this regulation. The quality was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements, which was dated March 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 relating to staffing, as set out in the policy.

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

Evidence of Implementation: There was an organisational chart in place which identified the leadership and management structure, and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. Staff had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

Opportunities were made available to staff by the approved centre for further education. The number and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was available within the approved centre. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff were trained in manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management, and treatment, incident reporting, and the protection of children and vulnerable adults.
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.

All staff training was documented and staff training logs were maintained. The following is a table of staff assigned to the approved centre.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creagh Suite</td>
<td>ADOM</td>
<td>0.25</td>
<td>On call</td>
</tr>
<tr>
<td></td>
<td>CNM3</td>
<td>0.25</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MTA</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>By referral</td>
<td>0</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Multitask Attendant (MTA)

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, the professional management of aggression and violence, 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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which were last reviewed in March 2018. The policy addressed 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: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence Of Implementation: Five clinical files were inspected in relation to residents’ records. All files inspected were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents’ current status and the care and treatment being provided. Resident records were physically stored together, where possible. Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident; and there were two appropriate resident identifiers recorded on all documentation.

Only authorised staff made entries in residents’ records, or specific sections therein. Records were legible and written in black indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Records were appropriately secured and stored in the nurses’ office to prevent loss, destruction, tampering, and unauthorised access or use.

Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had been trained on the complaints management process. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed for senior management to consider. Details of the analysis were considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

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

All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints were dealt with by the nominated person and recorded in the
complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process made available to them.

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

The approved centre was compliant with this regulation. The quality was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 32: Risk Management Procedures

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in November 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

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

Clinical risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of mechanical restraint and at admission, at resident transfer, and in conjunction with medication requirements or medication administration. The purpose of this was to identify individual risk factors.

Residents or their representatives were not involved in the risk management processes. Structural risks, including ligature points, remained but were effectively mitigated. Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre and were documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre as required. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was a basic emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated a basic evacuation procedure. Personal emergency evacuation plans (PEEPs) have been completed for each resident.

The approved centre was compliant with this regulation. The quality 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 33: Insurance

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

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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

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

**INSPECTION FINDINGS**

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

**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 Mechanical Restraint

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

The clinical files of two residents who had been mechanically restrained was inspected. Mechanical restraint was only practiced when each resident posed an enduring risk of harm to themselves or to others or to address a clinical need, and it was only used when less restrictive alternatives were not suitable. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist acting on his/her behalf.

Each of the two clinical files inspected contained a contemporaneous record that specified the following:

- That there was an enduring risk of harm to self or to others.
- That less restrictive alternatives were implemented without success.
- The type of mechanical restraint.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The approved centre was compliant with this rule.
Part 4 of the Mental Health Act 2001: Consent to Treatment, was not applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** There was a written policy in place dated February 2019 in relation to the use of physical restraint. The policy was reviewed annually. The policy detailed the provision of information to the resident, those who can and who may implement physical restraint, and child protection processes where a child is physically restrained.

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

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

**Evidence of Implementation:** The file of one resident who had been physically restrained was reviewed. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident’s unsafe behaviour. The restraint order lasted for less than 30 minutes.

Cultural awareness and gender sensitivity was demonstrated in the episode of physical restraint. The resident’s next of kin was informed about the physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in October 2016, the transfer policy was last reviewed in June 2017, and the discharge process policy was last reviewed in April 2018. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental health illness or mental disorder. The resident was assigned a key-worker. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information, such as 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: There were no discharges since the last inspection.

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

### Regulation 26: Staffing

**Reason ID: 10000160**

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

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Ongoing training being provided in all mandatory training areas on a monthly basis.</td>
<td>3 monthly audits</td>
<td>staff access to training and time allowed to attend these training sessions</td>
<td>23/12/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>continue to provide regular (usually monthly) training sessions locally on all mandatory training areas</td>
<td>3 monthly audits</td>
<td>staff access to training and time allowed to attend these training sessions</td>
<td>23/12/2019</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to “visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate”.

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

- a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
- b) See every patient the propriety of whose detention he or she has reason to doubt.
- c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
- d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.