Department of Psychiatry, Roscommon University Hospital

ID Number: AC0011

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, Roscommon University Hospital
Athlone Road
Roscommon
Co Roscommon

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health services, Community Healthcare West

Inspection Team:
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Inspection Date:
26 February – 1 March 2019

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
20-23 August 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 1 August 2019

2019 COMPLIANCE RATINGS

REGULATIONS
- Compliant: 26
- Non-compliant: 2
- Not applicable: 3

RULES AND PART 4 OF THE MENTAL HEALTH
- Compliant: 2
- Non-compliant: 2
- Not applicable: 2

CODES OF PRACTICE
- Compliant: 1
- Non-compliant: 1
- Not applicable: 1
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The approved centre was an acute admission unit located in Roscommon University Hospital. It was on the ground floor and occupied what had formerly been the maternity ward and was, therefore, not purpose-built. Although registered for 22 residents, there were 23 residents in the approved centre on the first day of the inspection. This had occurred on four other occasions since 1 January 2019.

Four sector teams had admitted to the approved centre. These comprised Roscommon, Ballinasloe, Portumna, Mountbellew, Glenamaddy and Athlone regions of Galway Roscommon mental health services. The Rehabilitation and Recovery team and the Psychiatry of Later Life also had admitting privileges.

Since 2017, when there was a compliance rate of 46% with regulations, rules and codes of practice, enormous efforts by management and staff had been put into increasing compliance and quality of care and treatment given. In 2018, the compliance rating increased to 79% and there was again an improvement in 2019 to 88%. There were 14 compliances rated as excellent, increased from 11 in 2018. All staff should feel justifiably proud of work done to achieve this.

Conditions to registration

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

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

**Finding on this inspection:** The approved centre was not in breach of Condition 1, in that there was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment, and progress updates had been provided to the Mental Health Commission. The approved centre was non-compliant with Regulation 22: Premises at the time of inspection. It was compliant with Regulation 21: Privacy.
Safety in the approved centre

- The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, and in conjunction with medication requirements or administration.
- Medication was ordered, prescribed, stored and administered in a safe manner. Food safety audits had been completed periodically and hygiene was maintained to support food safety requirements.

However:

- Hazards, including large open spaces, slippery floors, and hard and sharp edges, were not minimised in the approved centre. The shower tray in the high dependency unit bathroom was an identified slip, trip and fall risk. The second phase of anti-ligature works had not commenced and ligature points were not minimised to the lowest practicable levels.
- Not all healthcare professionals were up-to-date with Children First, Basic Life Support (BLS), fire safety, Mental Health Act 2001 training, or Therapeutic Management of Aggression and Violence (TMAV) or Management of Actual or Potential Aggression (MAPA). This was being actively managed and improvements noted year on year with the exception of non-consultant hospital doctors.

Appropriate care and treatment of residents

- Each resident had an individual care plan that outlined resident’s goals, interventions, and resources required to implement these. The individual care plans were multi-disciplinary and developed with the resident.
- Therapeutic activities were based on individual assessed need and were satisfactory.
- The monitoring of residents with enduring mental illness was excellent. At a minimum, a six-monthly health assessment had been completed, which included Body Mass Index (BMI), weight and waist circumference. This also detailed family and personal history, blood pressure, smoking and nutritional status, and a review of medication. An annual assessment of dental health had been completed. For those residents on antipsychotic medication, an assessment of glucose regulation, blood lipids and prolactin levels were recorded. ECGs had also been completed.

However:

- In all three episodes of physical restraint reviewed, there was no evidence to support that a medical examination of the resident had been completed no later than three hours after the start of the episode of restraint.
Respect for residents’ privacy, dignity and autonomy

- The resident search policy and procedures had been communicated to all residents. The residents had been informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance during the search which had been implemented with due regard to the resident’s dignity, privacy and gender.
- There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. A cleaning schedule was implemented and the approved centre was observed to be clean.
- Seclusion was carried out where necessary in accordance with the Rules Governing the Use of Seclusion and Mechanical Restraint.
- The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
- All bathrooms, showers, and toilets had locks on the inside of the doors and the locks had an override facility. Single bedrooms could not be locked from the inside following risk assessment. Where residents shared rooms that were dormitory style, bed screening was adequate and provided full screening to ensure residents’ privacy.
- The notice board displaying resident names and identifiable information had a folding mechanism and was available to clinical staff only.

Responsiveness to residents’ needs

- The approved centre provided access to recreational activities on weekdays and during the weekend. Notices outlining the weekly schedule of activities were displayed. Recreational activities provided included painting, drawing and card making, TV and movies, books and magazines, puzzles and board games. Active recreational activities included a yoga group, walking group and an exercise group. There was access to a table tennis table and an outdoor sensory garden.
- Information was available in written and verbal form about the approved centre, and residents’ diagnosis and medication.
- A complaints procedure was in place and complaints were addressed in a prompt manner.

Governance of the approved centre

- The approved centre was under the governance of Community Healthcare West which encompassed counties Mayo, Galway, and Roscommon. There were two area management teams; one was for the collective Galway and Roscommon Mental Health Services. The approved centre held a monthly business meeting and fixed agenda items included; health and safety, drugs and therapeutics, policies, procedures and audits, bed capacity, and the risk register. Membership included the business manager, quality and risk advisor, service user representative and a wide representation from clinical personnel.
- Service user representation was embedded in the governance structures with the area lead for mental health engagement on the executive management team and the Irish Advocacy Network.
(IAN) representative in attendance at the local business meetings. A peer support worker was employed to work on the Rehabilitation and Recovery Team but was also a member of committees within the approved centre and was an integral link with the Regari Recovery College in the town.

- Risk management processes were evident with a programme of ongoing training and development in risk management since the last inspection. Risk management workshops had taken place and the senior management team had received training. The approved centre, while it inputted all risks into the National Incident Management System (NIMs), had been using different incident report forms. The new HSE Incident Management Framework was being introduced. All clinical incidents were reviewed at the next respective multi-disciplinary team meeting. A due diligence process had commenced on the risk register and a review group for the risk register had been set up.

- There was emphasis on education and training. Nursing staff were mainly involved in the audit cycles; however, other healthcare professionals were becoming involved.

- There was evidence that the service was well-led and there was good collaboration and team working across all the clinical teams.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A smoking cessation group had commenced and was facilitated once weekly with residents in the approved centre.

2. The occupational therapy department had developed and introduced a referral form as an aid to improve communication within the teams and the occupational therapist on site in the approved centre.

3. Roscommon Sports Partnership attended the approved centre once weekly to facilitate an exercise group with the residents.

4. A self-help library had been introduced and was operational from the relaxation room.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located in Roscommon University Hospital. It was on the ground floor and occupied what had formerly been the maternity ward. Although registered for 22 residents, there were 23 residents in the approved centre on the first day of the inspection. This had occurred on four other occasions since 1 January 2019.

The approved centre was divided into two distinct areas separated by the main entrance located in a conservatory foyer. The bedroom area to the left comprised of dormitory style accommodation, one single bedroom and a high dependency unit with two single bedrooms and a seclusion suite. Despite being registered for 22 beds, there were 28 actual beds in the approved centre. A night sitting room was also located in this wing. To the right of the main entrance there was a number of staff offices, dining facilities, recreation and activity facilities including a sensory/relaxation room. There was a sensory garden located in the main foyer area which was available to residents throughout the day.

Four sector teams had admitting privileges to the approved centre. These comprised of all Roscommon, Ballinasloe, Portumna, Mountbellew, Glenamaddy and Athlone regions of Galway. The Rehabilitation and Recovery team and the Psychiatry of Later Life also had admitting privileges.

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>22</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>23</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>3</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>2</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was under the governance of Community Healthcare West which encompassed counties Mayo, Galway, and Roscommon. There were two area management teams and one was for the collective Galway and Roscommon Mental Health Services. There was an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the Galway/Roscommon Mental Health Service.

The approved centre held a monthly business meeting and fixed agenda items included; health and safety, drugs and therapeutics, policies procedures and audits, bed capacity, and the risk register. Membership
included the business manager, quality and risk advisor, service user representative and a wide representation from clinical personnel. All applicable items were referred to the area management team.

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

- Area Director of Nursing
- Occupational Therapy Manager representative
- Area Lead for Mental Health Engagement
- General Manager
- Quality and Patient Safety Advisor

The Mental Health Commission’s Governance questionnaire had been completed by the approved centre’s Principal Psychology Manager, Occupational Therapy Manager and Principal Social Worker.

The organisational chart outlined the governance structure. Reporting procedures throughout the approved centre were clearly defined. Service user representation was embedded in the governance structures with the area lead for mental health engagement on the executive management team and the Irish Advocacy Network (IAN) representative in attendance at the local business meetings. A peer support worker was employed to work on the Rehabilitation and Recovery Team but was also a member of committees within the approved centre and was an integral link with the Regari Recovery College in the town. This was managed under the auspices of the occupational therapy department.

Risk management processes were evident with a programme of ongoing training and development in risk management since the last inspection. Risk management workshops had taken place and the senior management team had received training. The approved centre while it inputted all risks into the National Incident Management System (NIMs) had been using different incident report forms. It was planned that the transition to the national standard National Incident Report Form (NIRF) was to commence the week after the inspection. The new HSE Incident Management Framework was being introduced. All clinical incidents were reviewed at the next respective multi-disciplinary team meeting. A due diligence process had commenced on the risk register and a review group for the risk register had been set up.

There was no system of performance appraisal for staff in the approved centre. Instead, it was reported that performance issues were addressed through clinical supervision. Staffing shortages were acknowledged as an ongoing challenge; however, this was mitigated for nursing with the use of regular overtime. Half of the consultant psychiatrist positions were vacant but this was also mitigated with locum posts. An occupational therapy position was being progressed through the National Recruitment Service (NRS), although this had taken considerable time.

There was good emphasis on education and training. Nursing staff were mainly involved in the audit cycles; however, it was noted that all other healthcare professionals were becoming involved. There was good collaboration and team working across all the clinical teams. Issues arising were reported as appropriate and, as applicable, discussed at the area management team. For example, residents had expressed a concern as to the numbers of staff in attendance not relating to their care, at their respective individual care planning (ICP) meetings. A protocol to address this had been identified.
Planned works, phase two of a refurbishment and ligature project, had not progressed. The inspection team were informed that this was due to capital expenditure restrictions and difficulty around acquiring access to a suitable design team.

3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Low</td>
<td>✓</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</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>
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<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
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<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
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<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
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<td>Regulation 9: Recreational Activities</td>
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<td>Regulation 10: Religion</td>
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<td>Regulation 11: Visits</td>
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<td>Regulation 12: Communication</td>
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<td>Regulation 13: Searches</td>
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<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
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<tr>
<td>Regulation 18: Transfer of Residents</td>
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<tr>
<td>Regulation 19: General Health</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
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<tr>
<td>Regulation 30: Mental Health Tribunals</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 had not admitted any children since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

The inspection team met with six residents. Residents were complimentary about the care and treatment, the facilities, the food and in particular the staff. The provision of physical health care needs was viewed very positively. All the residents interviewed knew their respective individual care plan and were familiar with their multi-disciplinary team members. One resident suggested that there were not enough toilets; this had also been stated by a resident on the previous inspection. A number of residents sought reassurance that the approved centre would not be closed down. These concerns were discussed with senior management who confirmed that there were no such plans.

Six completed resident questionnaires were also returned to the inspection team. All six indicated that the residents understood their care plan, and four of six indicated they knew who their key worker was. Five of six indicated that they had space for privacy and all six felt their privacy and dignity were respected. One of the six felt that there was not enough activities during the day. Four residents indicated that they ‘always’ felt safe in the approved centre with two indicating ‘sometimes’ to this question. On a scale of 1-10, with 1 being poor and 10 being excellent, two residents rated 10 out of 10 for overall experience of care and treatment, two residents rated 9, and two residents rated 8 and 7 respectively.

The Irish Advocacy Network (IAN) representative visited the approved centre weekly. There was a notice naming the IAN contact and details. A member of the inspection team spoke with the IAN representative to discuss issues and positive aspects as reported by residents. Concerns raised by residents to the advocate were that the approved centre could be cold in places and that there was not a lot of privacy in the seating areas. The food was described as excellent, the walks, exercise and music classes were very positive and the smoking cessations discussions were informative and helpful.
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:

- Area Director of Nursing
- Occupational Therapist
- Registered Proprietor and General Manager
- Business Manager
- Mental Health Act Administrator
- Social Worker
- Consultant Psychiatrist x 5
- Non Consultant Hospital Doctor
- Area Lead for Mental Health Engagement
- Staff Nurse
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Catering x 2
- Occupational Therapy Assistant
- Health Care Assistant
- Section Officer - Roscommon Mental Health Services

Apologies were received on behalf of the Executive Clinical Director and the Clinical Director.

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. Where applicable these have been included in the relevant section of the report.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in 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. Not all relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy. Staff gave different accounts as to the process for identification applied for same or similar named residents.

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. Identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare, therapeutic services, and programmes. A system for identifying residents with same or similar name was not in place.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 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 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 food and nutrition, as set out in the policy.

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

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals and food, including modified consistency diets. Meals were attractive and appealing in presentation. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times. Hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was used. Where appropriate, weight charts were implemented, monitored and acted upon. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. The needs of residents identified as having special nutritional requirements were assessed and addressed in the residents’ individual care plans. 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 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 interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

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

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

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. 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 two written policies in relation to residents’ clothing, which were last reviewed in March 2018. The policies included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Emergency clothing was available to residents in the approved centre. Residents changed out of nightclothes during the day unless otherwise specified in their individual care plans, and all residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of monies, valuables, and personal effects. The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Residents also had access to individual lockers with locks.

On admission, the approved centre compiled a detailed property checklist. These were filed separately from the resident’s individual care plan and were available to residents. Residents were supported to manage their own property, unless it posed a danger to the resident or others, as indicated in their 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 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 all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Notices outlining the weekly schedule of activities were displayed. Recreational activities provided included painting, drawing and card making, TV and movies, books and magazines, puzzles and board games. Active recreational activities included a yoga group, walking group and an exercise group. There was access to a table tennis table and an outdoor sensory garden.

The recreational activity programme had been developed, implemented and maintained for residents with resident involvement. Individual risk assessments had been completed in relation to the selection of appropriate activities. Resident decisions on whether to participate or not were respected and documented, as appropriate. The recreational activities were appropriately resourced and there were opportunities for indoor and outdoor exercise and physical activity. Documented records of attendance had been retained in group records and within the residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
## Regulation 10: Religion

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

### INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** Residents were facilitated to practice their religion insofar as was practicable. Mass was celebrated in the general hospital chapel adjacent to the approved centre. Residents had access to multi-faith chaplains.

The care and services provided in the approved centre were respectful of the residents’ religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed. Visiting areas were provided, including private visiting rooms. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visitors were requested to sign a book on arrival to the approved centre. Children visiting had been accompanied by an adult to ensure their safety and visiting areas were suitable for children.

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, e-mail, internet, and telephone unless otherwise risk assessed with due regard to the residents’ well-being, safety, and health. Risk assessments had been completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and documented in the individual care plan. The clinical director or senior staff only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The clinical file of a resident who had been searched was reviewed. Risk had been assessed prior to the search and resident consent had been sought. This was documented. The resident search policy and procedures had been communicated to all residents. The resident had been informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance during the search which had been implemented with due regard to the resident’s dignity, privacy and gender.
A written record of every search of a resident and every property search was available and included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Environmental searches had not been undertaken in the approved centre. Policy requirements had been implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 14: Care of the Dying

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

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident’s death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident’s death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

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

As no resident had died or had required end of life care since the last inspection, the monitoring and evidence of implementation pillars were not inspected against.

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 Judgment Support Framework.

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

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

Evidence of Implementation: Ten ICPs were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs included an individual risk management plan and a comprehensive discharge plan.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in 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 was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. The therapeutic services and programmes provided were evidence based. A combined therapeutic and recreational schedule was available and updated weekly. This had been coordinated by the occupational therapy department and examples of groups provided included relaxation, mindfulness, a recovery group, and a support and education group facilitated by Shine, a national mental health support organisation. Music and art therapy were also available. As required residents had one to one sessions with psychologists, social workers and occupational therapists from their respective teams.

Where a resident required a therapeutic service or programme that was not available internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Where applicable and following risk assessment residents also attended the local Regari Recovery College.

Therapeutic services and programmes were provided in separate dedicated rooms and records had been maintained of participation, engagement, and outcomes achieved, within the resident’s individual care plan or clinical file. There was a dedicated activities therapy room and a multi-sensory room. As applicable, occupational therapy outcomes were measured using a Comprehensive Occupational Therapy Evaluation (COTE) tool.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, 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.

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

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

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

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

(1) The registered proprietor shall ensure that:
   (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
   (b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
   (c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in August 2018. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the 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 policies.

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED) for which weekly checks had been completed.

Registered medical practitioners assessed residents’ physical health on admission, and general health needs were managed thereafter. At a minimum, a six-monthly health assessment had been completed. For those residents to which this was applicable a physical examination, which included BMI, weight and waist circumference, had been completed. This also detailed family and personal history, blood pressure, smoking and nutritional status and review of medication. An annual assessment of dental health had been completed. For those residents on antipsychotic medication an assessment of glucose regulation, blood lipids and prolactin levels were recorded. An ECG had been completed.

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

There was a policy on tobacco use and how smoking cessation was implemented. Nicotine replacement therapy was available and residents were supported to stop smoking. A smoking cessation group was facilitated weekly 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 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

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

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

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

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

Residents and their families received written and verbal information regarding diagnosis and the likely adverse effects of treatment. Medication information sheets as well as verbal information were provided, and these included information on indications for use and possible side effects of medication. The information provided by the approved centre was not always evidence-based and had not always been appropriately reviewed. As required, residents had access to interpretation and translation services.

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

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

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

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Residents wore clothing that respected their privacy and dignity. Staff were observed to use discretion when discussing the resident’s condition or treatment needs.

The approved centre’s layout and furnishings were not always conducive to resident privacy and dignity. All bathrooms, showers, and toilets had locks on the inside of the doors and the locks had an override facility. Single bedrooms could not be locked from the inside following risk assessment. Where residents shared rooms that were dormitory style, bed screening was adequate and provided full screening to ensure residents’ privacy. The notice board displaying resident names and identifiable information had a folding mechanism and was available to clinical staff only.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillars.
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 May 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The approved centre had not completed a hygiene audit since the last inspection. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space that included appropriately sized communal rooms, and to shared space in the form of well-lit and comfortably heated and ventilated communal rooms. There was sufficient space for residents to move about, including an outdoor sensory garden.

Appropriate signage and sensory aids were provided to support resident orientation needs. There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. A cleaning schedule was implemented and the approved centre was observed to be clean. Rooms were centrally heated but the temperature could not be controlled from the residents own room. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre, although one resident reported that there was not enough toilets. Wheelchair accessible toilet facilities were identified.
for use by residents and visitors who required such facilities. The approved centre had a designated sluice room, a designated cleaning room, and a laundry room. The approved centre provided assisted devices and equipment as required to address residents’ needs.

Hazards, including large open spaces, slippery floors, hard and sharp edges, were not minimised in the approved centre. The shower tray in the high dependency unit bathroom was an identified slip, trip and fall risk. The second phase of anti-ligature works had not commenced and ligature points were not minimised to the lowest practicable levels.

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

a) The shower tray in the high dependency unit was a hazard; therefore, the physical structure had not been properly maintained with due regard to the specific needs of the residents, 22(3).

b) Ligature points were not minimised to the lowest practicable levels; therefore, the approved centre had not been maintained with due regard to the safety of residents, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: The MPARs for ten of the residents were inspected. A record of allergies or sensitivities to any medications, including if the resident had no allergies, was documented for all. The generic names of medications and preparations were written in full with dedicated spaces for routine medications, once-off medications, and “as required” medications. The frequency of administration, the dosage, and the administration route for medications were recorded. There was a record of all medications administered to the residents, which included any medications refused by residents. There was a clear record of the date of initiation and discontinuation, where applicable, for each medication, along with the signature and Medical Council Registration Number of the medical practitioner. Not all entries on the MPARs had been written in black ink.

All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner and appropriately dispensed. The expiry dates of medications were checked prior to their administration, and good hand hygiene and cross infection control techniques were implemented when medication was being dispensed.

Controlled drugs were checked by two staff members against the delivery form, and the details were appropriately entered in the controlled drug book. At the time of inspection, no residents were self-administering medications and no resident had been prescribed medication to be crushed. Medication arriving from the pharmacy was verified against the order to ensure that it was correct and accompanied by appropriate directions for use. Medication was appropriately stored, and medication storage areas were clean and tidy. Food was not stored in areas used for the storage of medication. Where medication
required refrigeration, a log of the temperature of the refrigeration storage unit had been taken daily and recorded.

Medication was stored securely in a locked trolley within a locked room. There was a separate secure storage area for scheduled controlled drugs. A system of stock rotation was implemented, and an inventory of medications was completed monthly by nursing staff. Expiring medications were returned to the pharmacy.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.
(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in November 2018. It also had an associated safety statement, dated January 2019. The policy and safety statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- Infection control measures relating to covering of cuts and abrasions
- First aid response requirements

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements, which was last reviewed in April 2018. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. 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 that identified the leadership and management structure, lines of authority, and accountability of the approved centre’s staff. There was a planned and actual staff rota. The numbers and skill mix of staffing were sufficient to meet resident needs. A full time occupational therapy position had been progressed and was at expression of interest stage at the time of the inspection.

Staff had been recruited and selected in accordance with the approved centre’s policy and procedure, which was managed through the HSE National Recruitment Service. An appropriately qualified staff member was on duty and in charge at all times. There was no written staffing plan but there were defined processes to manage skill mix, competencies, number, and qualification of staff. The approved centre utilised agency staff and there was a comprehensive contract that set out the agency’s responsibilities, and included the vetting of staff.
An annual staff training plan had been completed that identified required training and skills development in line with the assessed needs of the resident group profile. Not all healthcare professionals were up-to-date with Children First, Basic Life Support (BLS), fire safety, Mental Health Act 2001 training, or Management of violence and aggression. This was being actively managed and improvements noted year on year with the exception of non-consultant hospital doctors.

Other training completed included manual handling, risk management, recovery-centred approaches, and care for residents with intellectual disability. All staff training had been documented and staff training logs were maintained. Opportunities had been made available to staff for further education and in-service training had been completed by appropriately trained individuals.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CNM3</td>
<td>1</td>
<td>1 (Acting)</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.5 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Assistant (OTA)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

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

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

a) Not all healthcare professionals had up-to-date mandatory training in Fire safety, Children First, Basic Life Support and management of violence and aggression.

b) Not all healthcare professionals had completed mandatory Mental Health Act 2001 training, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: Residents’ records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. There was however some clinical files with loose pages. The records were appropriately secured and where possible, were physically stored together.

A record had been initiated for every resident in the approved centre, and these were reflective of residents’ current status and the care and treatment being provided. Resident records were maintained through the use of an identifier that was unique to the resident, along with the resident name, address, and date of birth. Not all resident records were developed and maintained in a logical sequence and staff had difficulty retrieving some clinical information.
Records were written legibly and contained factual, consistent, and accurate entries. Each entry noted the time using the 24-hour clock and was followed by a signature. Only authorised staff made entries in residents’ records, or specific sections therein.

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

The approved centre was non-compliant with this regulation because clinical records were not all maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in 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 operating policies and procedures of the approved centre had been developed with input from clinical and managerial staff and in consultation with all relevant stakeholders as appropriate. The Clinical Policy Procedure Protocol Group, which encompassed the Galway/Roscommon Mental Health Services, had met every second month or more often if required.

The policies had been appropriately approved and had been communicated to all relevant staff. Policies that were required by regulation to be reviewed within three years were compliant. Obsolete versions were retained but had been removed from possible access by staff. The format was standardised. No generic policies had been used but had been appropriately referenced in applicable policies.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 30: Mental Health Tribunals

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in March 2017. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre had provided private facilities to support the Mental Health Tribunal Process. Adequate resources were available to support the Mental Health Tribunal process. Staff assisted and supported patients to attend and participate in the process, where necessary.

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

COMPLIANT
Quality Rating Satisfactory

(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 policy in relation to the management of complaints, which was last reviewed in September 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: Not all relevant staff had not been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood complaint policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed. Required actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

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

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All complaints were documented and dealt with by the local nominated complaints officer. A weekly forum was facilitated by staff where issues of concern relating to the running of the approved centre were recorded and addressed where appropriate.
The inspection was informed of the complaints that had been made to the nominated complaints officer for the wider service through the *Your Service Your Say* process since the last inspection. Details of complaints and of subsequent investigations and outcomes were fully recorded and kept distinct from residents’ individual care plans. The complainant’s satisfaction, or dissatisfaction, with the investigation findings was not documented.

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

COMPLIANT
Quality Rating Satisfactory

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed and updated in November 2018.

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

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

The policy did not address the following:

- The responsibilities of the Multi-Disciplinary Team.
- The process of identification for organisational risks.
- The process of identification for risks to the resident group during the provision of general care and services.
- The process for managing risks to the individual residents during the delivery of individualised care.
- The roles and responsibilities for key staff responding to specific emergencies.
- The process for communication responding to specific emergencies.

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

**Monitoring:** The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. 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 risk management policy had been implemented throughout the approved centre. Responsibilities were allocated at management level to ensure the effective implementation of risk management. The persons with responsibility for risk was known by all staff in the approved centre. The Quality Patient Safety advisor was also known by all staff. Risk management procedures actively sought to reduce identified risks. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register. Structural risks including ligature points were evident. Remediation works were partially completed but had not progressed. Associated risk was managed with individual risk assessment, individual care planning and staffing.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, and in conjunction with medication requirements or administration. The multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Incidents in the approved centre were recorded and risk-rated using an Incident and Near Miss Report form, and then inputted into the National Incident Management System. Plans were imminent for the approved centre to replace their incident forms with the national standard. Serious incidents were recorded using the HSE Safety Incident Management Communication/Escalation Form. There was a local incident review committee that met at least fortnightly. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission. Information provided was anonymous at resident level. The approved centre had an emergency plan that incorporated fire evacuation procedures. This was under review at the time of the inspection and has also been under review at the time of the 2018 inspection.

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently directly inside the main entrance of the approved centre.

The approved centre was compliant with this regulation.
8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

(4) In this section “patient” includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had not been reviewed annually and was dated February 2019. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion facility was furnished and maintained to ensure respect for resident dignity and privacy. Furniture and fittings were designed so as not to endanger patient safety. CCTV was not used in the approved centre.

Seclusion was initiated by a registered medical practitioner or a registered nurse. The consultant psychiatrist was notified as soon as was practicable. Seclusion occurred after an assessment, which included a risk assessment, and this was recorded in the clinical file and seclusion register by the person who had initiated it. The registered medical practitioner indicated the duration of the order. A medical review was undertaken no longer than four hours after the commencement of each episode of seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

Three episodes of seclusion were reviewed by the inspector. In each episode, seclusion had been used in rare and exceptional circumstances and in the resident’s best interests. Cultural awareness and gender sensitivity had been demonstrated. In each case, there was documented evidence that the resident had been informed of the reasons for, likely duration of, and circumstances leading to discontinuation of seclusion.
Residents were directly observed by a registered nurse for the duration of the seclusion episode and a written record of the resident was made every 15 minutes. A nursing review was undertaken every two hours and when applicable a medical review had been undertaken every four hours. The residents had been informed of the ending of the episode of seclusion and the reason for ending seclusion had been recorded in the respective clinical files. All uses of seclusion inspected had been clearly recorded on the seclusion register. A copy of the seclusion register had been placed in the clinical file. In each episode, there was documented evidence that there had been a review of the seclusion episode by members of the multi-disciplinary team within two working days after the episode of seclusion.

The approved centre was compliant with the Rules Governing the Use of Seclusion.
9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

56. - In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where—
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent –
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either–
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. The patient had consented to receiving treatment. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment. The written record of consent recorded the following:

- The name of the medications prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient which had taken place on the nature and purpose of the medications, the effects of the medications, including the risks and benefits and any views expressed by the patient, and any supports provided to the patient in making the decision to consent.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2019. It addressed the following:

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

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

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

Evidence of Implementation: Clinical files relating to three episodes of physical restraint were inspected. Physical restraint had been used in rare, exceptional circumstances and in the best interests of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated. There was evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

Physical restraint had been initiated by a registered medical practitioner, registered nurse, or other member of the multi-disciplinary team. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. The clinical practice form had been completed for each episode of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the residents’ needs and requirements in relation to the use of physical restraint. Residents were given the opportunity to discuss the episode with members of the multi-disciplinary team as soon as was practicable. Completed clinical practice forms had been placed in the resident’s clinical file.

In all three episodes reviewed, there was no evidence to support that a medical examination of the resident had been completed no later than three hours after the start of the episode of restraint.

The approved centre was non-compliant with this code of practice because there was no documented evidence that a registered medical practitioner had completed a medical examination of the resident no later than three hours after the start of the episode of restraint, 5.4.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in November 2016, addressed all the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in August 2018, addressed all the policy-related criteria for this code of practice. These included the procedure for involuntary transfer.

Discharge: The discharge policy, which was last reviewed in March 2018, addressed all the policy-related criteria for this code of practice. These included procedures for the discharge of involuntary patients and managing discharge against medical advice. There were protocols for discharging homeless people and older persons.

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

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

Evidence of Implementation:

The admission, transfer, and discharge processes were compliant under Regulation 32: Risk Management Procedures, which is associated with this code of practice.

Admission: One clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident’s family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged evidenced a discharge plan with an estimated date of discharge, documented communication with the relevant primary care team and a follow up plan with reference to early warning signs of relapse and risks. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to the relevant agencies and a comprehensive discharge summary had been sent within 14 days that detailed diagnosis, prognosis and medication. As applicable, a follow up appointment had been arranged for the resident.
The approved centre was compliant with this code of practice.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID : 10000117</th>
<th>Ligature points were not minimised to the lowest practicable levels; therefore, the approved centre had not been maintained with due regard to the safety of residents, 22(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Rhatigan Architects have visited and conducted their assessment. They have now been funded to complete design plans for phase 2 of window upgrade to anti-ligature standard. The upgrade will also include all bathrooms/showers on Approved Centre to be upgraded to the highest level of anti-ligature standard. The provision of a new front door is also included in the plans. Please see attached supportive documentation. Final plans will be submitted to the MHC when received.</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Rhatigan Architects have visited and conducted their assessment. They have now been funded to complete design plans for phase 2 of window upgrade to anti-ligature standard. The upgrade will also include all bathrooms/showers on Approved Centre to be upgraded to the highest level of anti-ligature standard. The provision of a new front door is also included in the plans. Please see attached supportive documentation. Final plans will be submitted to the MHC when received.</td>
<td>The completion of the plans will be recorded and monitored as will feedback from the registered Proprietor regarding funding of this essential urgent work.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Once design plans are complete capital funding will be sought to complete this work</td>
</tr>
</tbody>
</table>
Reason ID: 10000118

The shower tray in the high dependency unit was a hazard; therefore, the physical structure had not been properly maintained with due regard to the specific needs of the residents, 22(3).

<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>Rhatigan Architects have been commissioned to design plans for upgrade of all bathrooms including the High Dependency Unit shower. Please find attached documents as evidence that this is being progressed.</td>
<td>Rhatigan Architects have stated that the plans will be available in the next 2-3 weeks. Once received we will forward to MHC</td>
<td>Achievable but subject to approval by HSE of funding to begin schedule of works</td>
<td>27/02/2020</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Anti-slip mats being used to mitigate current risk and assistance and advise given to service users re same | We will attain the plans Record progress on same and funding and commencement of works at our monthly business | Achievable if funding is forthcoming | 27/02/2020 | The registered proprietor Clinical Director Assistant Director of Nursing |
### Regulation 26: Staffing

#### Reason ID: 10000119

<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>Training Template in place for all staff. Training will be provided and priority given to areas of greatest identified need via analysis of template.</td>
<td>Monitor Training Template to achieve 100% compliance for all mandatory training for staff</td>
<td>Achievable Has already improved and with prompting and provided training dates, compliance can be achieved</td>
<td>31/12/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Clinical Governance Audit Group Approved unit Roscommon will Track and advance attainment of compliance Identified deficits (eg new staff) will be monitored on an ongoing basis and training plans to address same will be put in place on an ongoing basis to prevent recurrence</td>
<td>Regular review of the Approved unit Roscommon Training Register</td>
<td>Achievable</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>
### Regulation 27: Maintenance of Records

**Reason ID: 10000121**

Clinical records were not all maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, 27(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative staff to ensure that all clinical files of inpatients within the DOP Roscommon meet the requirements of the JSF. All staff active to maintain records in good order. Replacement of Administrative staff lost to the approved unit due to transfer of staff</td>
<td>Informal reporting of loose pages to relevant staff</td>
<td>Formal quarterly audit until compliance attained MDT Reviews to highlight loose pages when noted</td>
<td>Achievable provided adequate administrative staff are provided to the Dept. of Psychiatry Roscommon</td>
<td>31/07/2019</td>
<td>Administrative Manager ADON Registered Proprietor Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to ensure approved unit has adequate administrative support Continue to monitor records Regular Maintenance of records audit</td>
<td>Informal daily monitoring Quarterly Audit until compliance achieved Audit as per JSF thereafter</td>
<td>Yes provided adequate administrative support is provided to the approved unit</td>
<td>30/09/2019</td>
<td>Senior Admin Manager ADON Clinical Director Registered Proprietor</td>
<td></td>
</tr>
<tr>
<td>Reason ID : 10000116</td>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>There was no documented evidence that a registered medical practitioner had completed a medical examination of the resident no later than three hours after the start of the episode of restraint, 5.4.</td>
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<tr>
<td><strong>Specific</strong></td>
<td>The mandatory physical examination had taken place but documentation was insufficient. To ensure compliance going forward a new physical examination document is in use which clearly documents the time. The MHC Checklist is used for every episode to prompt compliance with all requirements of the code.</td>
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<tr>
<td><strong>Measurable</strong></td>
<td>Yes, We complete the checklist for compliance with The Code of Practice for every episode of physical restraint and conduct Quarterly Audit of all episodes. The results are feedback to all relevant staff.</td>
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<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Achievable</td>
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<tr>
<td><strong>Time-bound</strong></td>
<td>25/06/2019</td>
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<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Clinical Director Assistant Director of Nursing CNM3</td>
<td></td>
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<tr>
<td><strong>Preventative Action</strong></td>
<td>An ongoing programme of Audit with associated relevant feedback and ongoing training will continue in the approved unit. This process has resulted in a very significant improvements and we hope to reach full compliance in the coming quarter. Please see attached documentation/checklist to improve compliance. The attached documentation was developed as a quality initiative by Staff on the Approved Centre to assist with compliance monitoring.</td>
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<tr>
<td><strong>Measurable</strong></td>
<td>Yes via quarterly audit and record of teaching sessions</td>
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<tr>
<td><strong>Achievable</strong></td>
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<td>Clinical Director Assistant Director of Nursing CNM3</td>
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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.