Department of Psychiatry, Midland Regional Hospital, Portlaoise

ID Number: AC0030

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, Midland Regional Hospital, Portlaoise
Portlaoise
Co Laois

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with
Intellectual Disability
Child and Adolescent Mental Health Care

Registered Proprietor:
HSE

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Inspection Team:
Susan O’Neill, Lead Inspector
Dr Enda Dooley, MCRN004155
Sarah Moynihan
Karen McCrohan

Inspection Date:
25 – 28 June 2019

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
8 – 11 May 2018

Registered Proprietor Nominee:
Ms Ger McCormack, General Manager, Mental Health Services, MLM CHO

Date of Publication:
Wednesday 22 January 2020

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

The Department of Psychiatry (DOP), Midland Regional Hospital, Portlaoise was the acute psychiatric unit for the Laois/Offaly area and within Community Healthcare Organisation (CHO) 8. It was located on the ground floor of the Midland Regional Hospital.

The approved centre operated at a maximum capacity of 46 residents and consisted of separate male and female wards. At the time of the inspection, there were 24 beds in the male ward and 22 in the female ward. Each ward contained a six-bed high observation area. Up to ten beds were allocated to the Kildare/West Wicklow area and could be occupied by residents transferred from Lakeview approved centre, which is in the CHO 7 area.

A total of ten multi-disciplinary teams admitted residents to the unit. These included six community teams (including one from the Kildare/West Wicklow area), psychiatry of old age, rehabilitation, intellectual disability, and young adult mental health team.

Compliance with regulations, rules and codes of practice has decreased slightly since 2017. In 2017, compliance was 77%, in 2018 it was 68% and in 2019 it was 70%. Seven non-compliances with regulations, rules and codes of practice had remained non-compliant for at least three years. There were six compliances with regulations that were rated as excellent.

Conditions to registration

There were two conditions 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 on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was in breach of Condition 1 and the approved centre was non-compliant with Regulations 21 and 22 at the time of inspection.
**Condition 2:** To ensure adherence to the Rules Governing the Use of Seclusion, the approved centre shall provide the Mental Health Commission with a report on the rate and duration of episodes of seclusion within the approved centre in a form and frequency prescribed by the Commission.

**Finding on this inspection:** The approved centre was not in breach of Condition 2.

**Safety in the approved centre**

- Appropriate hand-washing areas were provided for the catering service, catering areas and associated catering and food safety equipment were appropriately cleaned, and hygiene was maintained to support food safety requirements.
- Medication was ordered, prescribed, stored and administered in a safe manner.
- There was an emergency plan, which included an evacuation plan.

However:

- Ligature points had not been minimised. The ligature audit had identified a number of significant ligature risks requiring removal, including in bathrooms, showers, and bedrooms, which had not been addressed at the time of inspection.
- Not all staff had up-to-date mandatory training in Basic Life Support, Fire Safety, Children First, Therapeutic Management of Violence and Aggression and the Mental Health Act 2001.
- A food temperature log sheet was not maintained and monitored, resulting in food temperatures not being recorded in line with food safety recommendations.

**Appropriate care and treatment of residents**

- The approved centre’s menus were reviewed and approved by a dietician in order to ensure nutritional adequacy, in accordance with residents’ needs.
- Each resident had a multidisciplinary care plan, which was developed with the resident and regularly reviewed. It contained an assessment of the resident’s needs, agreed goals, interventions to meet the goals and the required resources.
- Each resident received appropriate general health care interventions in line with their Individual Care Plan.

However:

- While it was possible for residents to be referred for assessment, allied health professionals were not involved in the design or provision of therapeutic programmes within the approved centre, and there was no dedicated occupational therapy input.
- Residents located in the high dependency unit (HDU) did not have access to therapeutic programmes. They were not offered programmes and were not assessed for participation in recovery programmes until they had left the HDU.
• There was a lack of essential monitoring of the physical status of residents who had been cared for in the approved centre for six months or more. Three residents did not have their Body Mass Index (BMI) and waist circumference measured. Three files did not include the residents’ smoking status, two files did not record the residents’ nutritional status, and two files did not include a record of a dental check. Of those residents prescribed anti-psychotic medication, one did not have an assessment of fasting glucose, two residents did not have an assessment of the blood lipids, one resident did not have an ECG, and one did not have a prolactin test.

• There were 9 admissions of children under the age of 18 years. Age-appropriate facilities and a programme of activities were not provided.

Respect for residents’ privacy, dignity and autonomy

• All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. When residents were required to share a bedroom, bed screening ensured that their privacy was not compromised. All observation panels on the doors of treatment rooms and bedrooms were fitted with blinds, curtains, and opaque glass. Noticeboards within the nurse’s stations were not visible to residents.

• The design of the physical environment of the approved centre had appropriately-sized communal rooms, and also provided residents with access to adequate personal space. The lighting in the communal rooms suited the needs of both residents and staff, being sufficiently bright enough to facilitate reading and other activities.

• The exterior of the premises had been repainted and generally improved upon since the previous inspection. There was an ongoing programme of general and decorative maintenance, cleaning, decontamination, and the repair of assistive equipment, of which records were maintained.

• A cleaning schedule was implemented, and the approved centre was generally clean, hygienic, and free from offensive odours throughout.

• Clear signs were on display in prominent positions notifying residents and the public of the use of CCTV. Residents were monitored only for safety purposes, and cameras did not have recording capacity. CCTV images could only be seen by staff. CCTV was not used to monitor residents in a way that compromised dignity, but rather in order for staff to intervene when a resident was acting in a compromising way.

• All resident records were secure, up to date, in good order, with no loose pages, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements.

However:

• During administration of ECT for one patient, consent was not obtained in writing for the eighth and ninth ECT treatment session, including anaesthesia. Appropriate information on ECT was not given by the consultant psychiatrist to enable the patient to make a decision on consent for each treatment session of ECT and a comprehensive assessment of capacity by the consultant psychiatrist was not completed. This non-compliance with the Rules Governing the Use of Electro-Convulsive Therapy was
risk rated as critical. An Immediate Action Notice was issued to the registered proprietor of the approved centre following inspection.

- The bathroom and shower facilities for the male seclusion room were across the corridor. Having to cross over from the seclusion room to use the facilities was not respectful of the residents’ privacy and dignity.
- The interior of the approved centre was not kept in a good state of repair. There was general wear and tear and staining evident in a number of toilets, shower and bath areas.

**Human Rights**

There was one breach of human rights noted in the approved centre at the time of inspection:

During a programme of ECT for one detained patient, informed consent for receiving ECT was not obtained in writing for the eighth and ninth ECT treatment session, including anaesthesia.

**Responsiveness to residents’ needs**

- Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, and were given at least two choices for each meal. Food was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.
- Recreational activities were provided for residents during the week and at weekends.
- Written information was provided to residents about the approved centre, mental health diagnoses and medications.
- There was a responsive complaints procedure in place.

**Governance of the approved centre**

- The approved centre was under the governance of the Laois/Offaly Mental Health Services and within the overall governance of the Midlands Louth Meath Community Healthcare Organisation. There was a Laois/Offaly Senior Management Team consisting of heads of services and discipline.
- Senior nursing management within the approved centre provided reports relating to quality and governance issues to the Laois/Offaly Senior Management team meeting.
- The approved centre maintained a risk register which was reviewed at the local Health and Safety meeting which occurred every three months and was attended by members of the nursing, catering and maintenance team.
- Staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training due to difficulties in planning training sessions and releasing staff from duty to attend these sessions. Staff performance appraisals were not completed for the majority of disciplines.
- At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident
and carer involvement in the process of quality improvement. At an area level, the Area Lead for Mental Health Engagement attended the monthly Laois/Offaly Senior Management Team meetings.

- Systems in place to support quality improvement included a programme of audit. However, the multidisciplinary team were not involved, and the majority of audits were undertaken by the nursing team.

However:

- Multi-disciplinary participation within the local system of governance was absent within the approved centre. Previously, a multi-disciplinary Approved Centre Governance meeting occurred on a bimonthly basis; however, these meetings were discontinued in October 2018 due to poor attendance from the multi-disciplinary team. At the time of the inspection, there were no plans to reinstitute a forum for the multi-disciplinary oversight of local clinical governance.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Provision of a “Room for Reflection” in the male admission unit.

2. Renovation of courtyard area to improve safety and appearance.

3. Establishment of a multi-disciplinary policy review group.

4. Refurbishment of the reception area.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry (DOP), Midland Regional Hospital, Portlaoise was the acute psychiatric unit for the Laois/Offaly area and within Community Healthcare Organisation (CHO) 8. Opened in 2004, the approved centre was purpose-built and was situated off the Block Road on the Dublin side of Portlaoise. It was located on the ground floor within the southern section of the Midland Regional Hospital, Portlaoise building.

The approved centre was accessed through the main entrance on the north side of the hospital. The approved centre operated at a maximum capacity of 46 residents and consisted of separate male and female wards. At the time of the inspection, there were 24 beds in the male ward and 22 in the female ward. Each ward contained a six-bed high observation area, in which a nurse was present at all times.

A total of ten multi-disciplinary teams admitted residents to the unit. These included six community teams (including one from the Kildare/West Wicklow area), psychiatry of old age, rehabilitation, intellectual disability, and young adult mental health team. Up to ten beds were allocated to the Kildare/West Wicklow area and could be occupied by residents transferred from Lakeview approved centre, which is in the CHO 7 area.

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>46</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>38</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>1</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>6</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was under the governance of the Laois/Offaly Mental Health Services and within the overall governance of the Midlands Louth Meath Community Healthcare Organisation. At an area level, the Laois/Offaly Senior Management Team meeting took place on a monthly basis at St. Fintan’s Hospital in Portlaoise. This was attended by heads of services and discipline. Standing agenda items pertained to operational, quality and clinical governance issues.

Multi-disciplinary participation within the local system of governance was absent within the approved centre. Previously, a multi-disciplinary Approved Centre Governance meeting occurred on a bimonthly basis;
however, these meetings were discontinued in October 2018 due to poor attendance from the multidisciplinary team. At the time of the inspection, there were no plans to reinstitute a forum for the multidisciplinary oversight of local clinical governance. Senior nursing management within the approved centre provided reports relating to quality and governance issues to the Laois/Offaly Senior Management team meeting.

The approved centre maintained a risk register which highlighted various clinical and health and safety risks. The risk register was reviewed at the local Health and Safety meeting which occurred every three months and was attended by members of the nursing, catering and maintenance team. Where required, the Risk and Patient Safety Advisor provided advice and support to the service in relation to risk management issues.

The approved centre had an adequate number of staff and skill mix to meet residents’ needs. Vacant posts were noted within sector teams for specific disciplines; however, adequate short-term service cover was in place and plans for recruitment were in progress. Staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training. Difficulties in planning training sessions and releasing staff from duty to attend these sessions was highlighted by senior management within the approved centre. Staff performance appraisals were not completed for the majority of disciplines. Supervision sessions were undertaken but mostly within a group format and not on an individual basis.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. Residents also had access to advocacy services if required; advocacy contact details were displayed within the approved centre. At an area level, the Area Lead for Mental Health Engagement attended the monthly Laois/Offaly Senior Management Team meetings.

Systems in place to support quality improvement included a programme of audit however, the multidisciplinary team were poorly integrated in this respect, and the majority of audits were undertaken by the nursing 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 6: Food Safety</td>
<td>✔</td>
<td>✔</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>✔</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✔ Moderate</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Moderate</td>
<td>Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✔</td>
<td>X High</td>
<td>X Critical</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Code of Practice on the Admission of Children under the Mental Health Act 2001</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>High</td>
<td>Low</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<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 no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As no resident had been mechanically restrained since the last inspection, this rule 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.

During the course of the inspection, the inspection team met with six residents individually. The majority of residents were complimentary of the staff and the care they received. All residents were familiar with the multi-disciplinary team and their care plan; however, some reported that they didn’t receive a copy of the care plan. The majority of residents were happy with the food but one person did comment that it was sometimes unvarying. One person commented on the lack of access to therapeutic services while admitted to the high observation area. While most residents enjoyed the recovery programme activities in some capacity, one person stated that programme did not cater for varying capabilities.

The IAN representative also met with the inspection team and provided a report on service user feedback. Positive aspects of the service included the quality of food, the friendliness of staff, and new developments including the garden area and the quiet room on the male unit. Many areas reported as requiring improvement echoed resident interviews. These included access to therapies in high observation areas, offering of care plans to residents, and activation classes that were considered not challenging enough. Another issue raised was that the noticeboard on the female unit did not always display the names of key nurses.
A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Assistant Director of Nursing, 1 x 3
- Clinical Nurse Manager 3
- Acting Clinical Nurse Manager 2
- Consultant Psychiatrist (Acting Clinical Director)
- Consultant Psychiatrist
- Senior Clinical Psychologist
- Senior Occupational Therapist
- Senior Pharmacist
- Principal Social Worker
- Mental Health Administrator

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

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

The following regulations are not applicable

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

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 March 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Clear, documented analysis had not 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 to individual residents’ needs, were used to ensure that residents were easily identifiable by clinical staff. The preferred identifiers used for each resident were detailed within residents’ clinical files. Identifiers used were person-specific, not including the resident’s room number or physical location, and were checked when staff were administering medications; undertook medical investigations; and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. While there were no residents with the same or similar names resident in the approved centre during the inspection, appropriate identifiers and alerts were used to assist staff to distinguish between residents when necessary.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 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 July 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 not been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre’s menus were reviewed and approved by a dietician in order to ensure nutritional adequacy, in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, and were given at least two choices for each meal. Food was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot meals were served on a daily basis. Hot and cold drinks were offered to residents regularly, and a source of safe, fresh drinking water, found in easily accessible locations throughout the approved centre, was available to residents at all times.

The needs of residents requiring special nutritional plans were reviewed regularly by a dietician in the approved centre. An evidence-based nutrition assessment tool was not routinely used, only being used when a resident was referred to the dietician. However, if a resident needs to see a dietitian, the MUST (Malnutrition Universal Screening Tool) assessment tool was used prior to the referral. Weight assessment charts were implemented, monitored, and acted upon for residents, where necessary. Residents, their representatives, families, and next of kin were not educated about the residents’ diets, specifically in relation to any contraindications with medication. Nutritional and dietary needs were assessed and, where necessary, addressed in residents’ individual care plans. Intake and output charts were initiated and maintained for residents, as clinically required.

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 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 March 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food 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 not recorded in line with food safety recommendations. A food temperature log sheet was not maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: The approved centre had suitable and sufficient catering equipment, and there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was cooked in the main hospital and transported to the approved centre.

Appropriate hand-washing areas were provided for the catering service, catering areas and associated catering and food safety equipment were appropriately cleaned, and 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 non-compliant with this regulation because no food temperatures were recorded, in line with food safety recommendations, for four days within a two week period, 6(2)(c).
Regulation 7: Clothing

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

**INSPECTION FINDINGS**

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

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

**Monitoring:** The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. A record of residents wearing nightclothes during the day was maintained and monitored. No residents were wearing nightclothes at the time of inspection.

**Evidence of Implementation:** Residents were supported to keep and use their own personal clothing and all residents were wearing clothing that was clean and appropriate to their needs. Residents were provided with appropriate emergency clothing that took account of their preferences, dignity, bodily integrity, and religious and cultural practices. For longer-term needs, the approved centre had an account with a local clothing shop where residents could be provided with suitable clothing, as required. Residents changed out of nightclothes during daytime hours, unless otherwise specified in their individual care plans.

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

**COMPLIANT**

**Quality Rating**

Excellent
Regulation 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 December 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents’ 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: Secure facilities were supplied for the safe-keeping of residents’ property, possessions, monies and valuables, as applicable. At the time of the inspection, any small amounts of cash were placed in a secure safe in a locked room within the approved centre, while larger amounts were remitted to the main hospital.

Upon admission, the approved centre compiled a checklist with each resident of their personal property and possessions, which was updated on an ongoing basis. Each resident’s property checklist was kept separately to their individual care plan (ICP), and was freely available to the resident.

Residents were supported to manage their own property, unless it posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen and signed for by two members of staff, or by the resident and one member of staff.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
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 August 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 recreational activities, as set out in the policy.

Monitoring: A record was not maintained of the occurrence of planned recreational activities. Documented analysis had not 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. Information on recreational activities was provided to residents in an accessible format, both through the activities timetable, and using verbal communication. The information included the types and frequency of appropriate recreational activities available within the approved centre. Communal areas were provided that were suitable for recreational activities, including sitting rooms on both the male and female wards, a relaxation room, two therapy rooms and an outdoor garden. At the time of inspection, the recreational activity programme provided limited opportunities for indoor and outdoor exercise and physical activity.

Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. Individual risk assessments were completed for residents in relation to the selection of appropriate activities, and resident decisions on whether or not to participate in activities were respected and documented. The recreational activities provided by the approved centre were appropriately resourced. Documented records of attendance were retained for recreational activities in group records or within residents’ clinical files, as appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
Regulation 10: Religion

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

**INSPECTION FINDINGS**

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

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

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

**Evidence of Implementation:** Residents’ religious beliefs were assessed and recorded on admission to the approved centre. Residents’ rights to practice religion were facilitated, insofar as was practicable: facilities were provided within the approved centre for residents’ religious practices, and residents were supported to attend local religious services in a nearby church, if appropriate. Residents could use the oratory in the main hospital. For Roman Catholic residents, communion was provided twice weekly. Any specific religious requirements relating to the provision of services, care and treatment were clearly documented in residents’ clinical files. 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. 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 were able to articulate the processes for visits, as set out in the policy.

Monitoring: Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A number of multi-purpose rooms were available for visiting, where residents could meet visitors in private, unless there was an identified risk to others, or an identified health and safety risk. The approved centre also had a designated family room for visiting children.

Appropriate steps had been taken to ensure the safety of residents and visitors during visits. Children were permitted to visit if accompanied by an adult at all times. This was clearly and publicly communicated to all relevant individuals.

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Any restriction on communication was monitored as part of the risk assessment process. Ongoing documented analysis was undertaken to identify opportunities to improve the communications processes.

Evidence of Implementation: The policy in the approved centre was for residents to have access to personal mobile phones and smartphones, unless it had been risk assessed otherwise. Where staff had reasonable cause to believe that communication would be of harm to a resident, the clinical director, or a senior staff member delegated by the clinical director, would examine the resident’s incoming and outgoing communications. Any limitation of a resident’s communications was documented in that resident’s individual care plan.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in March 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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. However, documented analysis had not been completed to identify ways of improving search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file and search form of one resident who had undergone a search was inspected. Risk had been assessed prior to the search of the resident and of their belongings. The resident search policy and procedures were communicated to all residents upon admission, and prior to each individual search. Residents were informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the reviewed search was being conducted. The inspected search was
implemented with due regard to the resident’s dignity, privacy and gender, and all of the staff members who conducted the search were the same gender as the resident being searched. Search forms had been completed for the clinical file reviewed, and the resident’s consent had been obtained and documented.

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

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
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 the care of the dying. The policy was last reviewed in May 2019. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- Advanced directives in relation to end of life care, DNAR orders, and residents’ religious and cultural end of life preferences.
- The process for ensuring that the approved centre is informed in the event of the death of a resident.

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

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

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

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 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not 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’ individual care plans (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: All residents had an ICP, of which ten were inspected. All ICPs investigated comprised a composite set of documents with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable, were uninterrupted, and were not amalgamated with progress notes.

Each resident was initially assessed at admission, and an ICP was completed by the admitting clinician to address immediate needs of the residents. These initial care plans were superseded by ICPs, which were developed by the MDT within seven days of admission.

As the keyworker was shift dependent, specified keyworkers were not identified in residents’ ICPs. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representatives, family, and next of kin, where appropriate.

The ICPs identified appropriate goals, treatment and care, and the necessary resources for each resident. All ICPs were developed, regularly reviewed, and updated by the residents’ MDT. Residents had access to their initial ICPs, which they were offered a copy of, and were kept informed of any changes to the plan, however, they were not offered a copy of ICP review. When a resident declined or refused a copy of their initial care plan, this was recorded. However, there was no documentation of residents’ refusal of ICPs following review of their ICP.

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 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 August 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not 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: A list of all therapeutic services and programmes provided in the approved centre was available to residents. The therapeutic services and programmes provided by the approved centre were evidence-based and were reflective of good practice guidelines. However, residents located in the high dependency unit (HDU) did not have access to therapeutic programmes directed towards restoring and maintaining optimal levels of functioning. They were not offered programmes and were not assessed for participation in recovery programmes until they had left the HDU.

There was a separate dedicated activities and therapy room available in the approved centre, however adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes. While it was possible for residents to be referred for assessment, allied health professionals were not involved in the design or provision of therapeutic programmes within the approved centre, and there was no dedicated occupational therapy input.

While a record was maintained of resident participation and engagement with therapeutic services and programmes, this record was non-specific, making it unsuitable for critical analysis of the effectiveness or appropriateness of the services and programmes.

The approved centre was non-compliant with this regulation because residents in the high dependency unit were not provided with therapeutic services and programmes which were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning, 16(2).
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 May 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** The clinical file of one resident who had been transferred from the approved centre was examined. Communication records with the receiving facility, and their agreement to receive the resident in advance of the transfer, were documented.

Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer, including the reasons for transfer and the resident’s care and treatment plan, which included the resident’s needs and risks. There was a record indicating the resident’s accompaniment requirements on transfer.

The resident was risk assessed prior to the transfer, and the residents consent to transfer was documented. The following information was issued, with copies retained, as part of the transfer documentation: a letter of referral, including a list of the resident’s current medications; a resident transfer form; and a checklist completed by the approved centre to ensure that comprehensive resident records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.
Regulation 19: General Health

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. Both the general health policy and the medical emergencies policy were last reviewed in March 2017. The policies and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: While 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, not all relevant staff had signed the signature log to indicate that they had read and understood them.

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

Evidence of Implementation: The approved centre had an emergency resuscitation trolley, and staff had access to an Automated External Defibrillator (AED) at all times. The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre, and of the care and treatment that was provided in response.

Each resident received appropriate general health care interventions in line with their ICP. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, and each of the files inspected evidenced that all residents had received a six-monthly general health assessment.

The clinical files of five residents who had been cared for in the approved centre for six months or more were assessed. Of the five files reviewed, three did not include the residents’ Body Mass Index (BMI) and waist circumference, three files did not include the residents’ smoking status, two files did not record the residents’ nutritional status, and two files did not include a record of a dental check. Four of the five residents had been prescribed anti-psychotic medication; however, one of the five files did not include an assessment of the resident’s fasting glucose, two of the four did not include an assessment of the residents’ blood lipids, one of the four did not contain a record of an ECG, and one of the four did not include results of a prolactin test.
Records were available demonstrating the residents’ completed general health checks and the associated results. Residents could access general health services and be referred to other health services. Residents had information on, and could access, appropriate national screening programmes. There was a local policy on tobacco use, and residents were supported to stop smoking.

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

a) All six-monthly general health assessments did not document BMI, waist circumference, smoking status, nutritional status, or dental health, 19(1)(b).

b) For residents on antipsychotic medication, an annual assessment including glucose regulation, blood lipids, heart health via an electrocardiogram exam, or prolactin levels was not undertaken for all residents, 19(1)(b).
(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. 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: Not all staff, particularly medical staff, had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

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

Evidence of Implementation: Residents were provided with a simply-written, user-friendly booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and arrangements, and relevant advocacy and voluntary agencies. Residents were also provided with the details of their multi-disciplinary team, and MDT details were displayed on noticeboards in the approved centre.

Residents were provided with written and verbal information concerning their diagnosis, unless the treating psychiatrist had cause to believe that the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. At the time of the inspection, there were no restrictions relating to the provision of information being applied to any resident.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets, as well as verbal information, were provided in a format appropriate to the residents’ needs. The content of medication information sheets included information for the use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.
Regulation 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 March 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exception:

- The approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

**Training and Education:** While all staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy, not all staff had signed the signature log to indicate that they had read and understood the policy.

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

**Evidence of Implementation:** Residents were called by their preferred name. The general demeanour of staff, and the way in which staff addressed and interacted with residents was respectful. Staff were discreet when discussing the residents’ condition or treatment needs. All residents were wearing clothes that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a certain resident. When residents were required to share a bedroom, bed screening ensured that their privacy was not compromised. All observation panels on the doors of treatment rooms and bedrooms were fitted with blinds, curtains, and opaque glass. Patients were facilitated to make private phone calls.

Noticeboards within the nurse’s stations were not visible to residents. A second noticeboard outside the nurses’ station, which was visible to residents, did not display any identifiable resident information. The bathroom and shower facilities for the male seclusion room were across the corridor. Having to cross over from the seclusion room to use the facilities was not respectful of the residents’ privacy and dignity.

The approved centre was non-compliant with this regulation because male residents in seclusion were required to cross the hallway to use the bathroom and shower facilities.
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 2017. The policy addressed requirements of the Judgement Support Framework, including the roles and responsibilities for the maintenance of the approved centre’s premises and related processes, and the legislative requirements to which the premises must conform, but omitted the following requirements:

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

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

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

Evidence of Implementation: The design of the physical environment of the approved centre had appropriately-sized communal rooms, and also provided residents with access to adequate personal space. The lighting in the communal rooms suited the needs of both residents and staff, being sufficiently bright enough to facilitate reading and other activities.
Ligature points had not been minimised. The ligature audit had identified a number of significant ligature risks requiring removal, including in bathrooms, showers, and bedrooms, which had not been addressed at the time of inspection.

Suitable furnishings supported residents’ independence and comfort, but the interior of the approved centre was not kept in a good state of repair. There was general wear and tear and staining evident in a number of toilets, shower and bath areas.

The exterior of the premises had been repainted and generally improved upon since the previous inspection. There was an ongoing programme of general and decorative maintenance, cleaning, decontamination, and the repair of assistive equipment, of which records were maintained. A cleaning schedule was implemented, and the approved centre was generally clean, hygienic, and free from offensive odours throughout.

Rooms were centrally heated, with radiators guarded, but the heating was controlled centrally through the Building Management System, and could not be controlled by residents from their own rooms. There was a designated laundry and sluice room. Remote or isolated areas of the approved centre were monitored.

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

a) Some areas of the premises were not maintained in good structural and decorative condition, 22(1)(a).

b) There were a large number of high risk ligature points evident which had not been minimised. The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and well-being 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. The policy was last reviewed in July 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All pharmacy staff, but not 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, as well as pharmacy staff, had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

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

All entries in the MPAR were legible, and written in black indelible ink. Medication was reviewed and rewritten at least six-monthly, or more frequently where there was a significant change in the resident’s care or condition. This was documented in the clinical file. In two of the ten MPARs, alterations had been made to the prescription without a new prescription being written. The expiration date of the medication being used was checked prior to administration, and expired medications were not administered. All medications were administered by a registered nurse or a registered medical practitioner, and any advice provided by the resident’s pharmacist regarding the appropriate use of a product was adhered to.

Good hand hygiene techniques were implemented during the dispensing of medications. When a resident’s medication was withheld, the justification was noted in the MPAR, and also documented in the clinical file. Medication was stored in the appropriate environment, as advised by the pharmacist. However, where medication required refrigeration, a log of the temperature of the refrigeration storage unit had not been taken and recorded on a daily basis.
The medication storage area was free from damp and mould, clean, free from litter, dust and pests, and free from spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules. An inventory of medications was conducted on a monthly basis, checking the name and dose of the medication, its quantity, and expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required, were stored in a secure manner, segregated from other medications, and were returned to the pharmacy for disposal.

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 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in March 2018. The approved centre also had an associated site-specific safety statements, with individual folders for both the male and female wards, the rehabilitation unit, and the kitchenette. The policy and safety statements were last reviewed in February 2019. The policy and safety statement addressed the requirements of the Judgement Support Framework, with the following exceptions:

- Infection control measures, including; safe handling and disposal of health care risk waste, the management of spillages, raising awareness of residents and their visitors to infection control measures, hand washing, linen handling and the covering of cuts and abrasions.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes 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.
(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:
   (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
   (b) it shall be clearly labelled and be evident;
   (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
   (d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
   (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.
(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.
(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2017. The policy the requirements of the Judgement Support Framework, except for the requirement that CCTV cameras would be maintained by the approved centre.

Training and Education: All relevant 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 use of CCTV, as set out in the policy.

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: Clear signs were on display in prominent positions notifying residents and the public of the use of CCTV. Residents were monitored only for safety purposes, and cameras did not have recording capacity. CCTV images could only be seen by staff. CCTV was not used to monitor residents in a way that compromised dignity, but rather in order for staff to intervene when a resident was acting in a compromising way. The Mental Health Commission had been informed of the approved centre’s use of CCTV.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in May 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. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

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

Annual staff training plans were completed for all staff to identify required training and skills development, in line with the assessed needs of the resident group profile, however not all staff had up-to-date mandatory training in Basic Life Support, Fire Safety, Children First and Therapeutic Management.
of Violence and Aggression. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and the Mental Health Commission Rules and Codes, as well as all other relevant Mental Health Commission documentation and guidance, were available to staff throughout the approved centre. Opportunities were made available to staff by the approved centre for further education, and these opportunities were effectively communicated to all relevant staff.

The following is a table of the training of clinical staff within the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (43)</td>
<td>40</td>
<td>38</td>
<td>39</td>
<td>39</td>
<td>43</td>
</tr>
<tr>
<td>Consultant Psychiatrist (13)</td>
<td>8</td>
<td>11</td>
<td>8</td>
<td>10</td>
<td>12</td>
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<tr>
<td>Medical (20)</td>
<td>16</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>20</td>
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<tr>
<td>Occupational Therapist (5)</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Social Worker (7)</td>
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<td>6</td>
<td>5</td>
<td>5</td>
<td>6</td>
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<tr>
<td>Psychologist (5)</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

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>Male Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNM2</td>
<td>1</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>CNM3</td>
<td>0.5 WTE</td>
<td>0.5 WTE</td>
<td></td>
</tr>
<tr>
<td>RPN</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>HCA</td>
<td>1</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNM2</td>
<td>1</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>CNM3</td>
<td>0.5 WTE</td>
<td>0.5 WTE</td>
<td></td>
</tr>
<tr>
<td>RPN</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>HCA</td>
<td>1</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Occupational Therapy, Psychology, and Social work provided on an in-reach basis

*Whole time equivalent (WTE), 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 staff had up-to-date mandatory training in Basic Life Support, fire safety, Children First and Therapeutic Management of Violence and Aggression, 26(4).

b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in July 2016, with a subsequent revision due in July 2019. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The records required to be created for each resident and what they should contain.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.
- The destruction of records.
- The relevant legislative requirements relating to record maintenance: the implementation of the Data Protection Acts, Freedom of Information Acts and associated controls for records.
- The process for making a retrospective entry in residents’ records.

The policy and procedures did not address the following:

- The ways in which entries in residents’ records are made, corrected and overwritten.
- General safety and security measures in relation to record (stored in a locked room or cupboard).

Training and Education: Not 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/policies. All clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: A record was created for each resident assessed or provided with care or services by the approved centre. Resident records were reflective of the residents’ current status and the care and treatment that was being provided to them. Resident records were accessible to authorised staff...
only: staff only had access to the data and information needed to carry out their job responsibilities, and records were managed in accordance with the Data Protection Acts.

All resident records were secure, up to date, in good order, with no loose pages, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Records were physically stored together, as far as possible, and were developed and maintained in a logical sequence. All records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers in all documentation.

Only authorised staff made entries in residents’ records. Hand-written records were legible: entries were written in black indelible ink, and were readable when photocopied. Entries in resident records were factual, consistent, and accurate, and did not contain jargon, unapproved abbreviations, or meaningless phrases. Where a member of staff made a referral to, or consulted with, another member of the health care team, the person was clearly identified using their full name and title. The approved centre did not maintain a record of all signatures used in the resident record.

Records were appropriately secured throughout the approved centre from loss, destruction or tampering, and unauthorised access or use. Records were retained or destroyed in accordance with legislative requirements, and with the policy and procedures of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented electronic register of residents admitted to the approved centre, which was available to the Mental Health Commission. It included all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulation 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 March 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 in operational policies and procedures, and could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policy and procedures were developed with input from clinical and managerial staff, and in consultation with relevant stakeholders, including service users. Relevant legislation, evidence-based practice, and clinical guidelines were integrated into the policy. The policies and procedures were appropriately approved, and were communicated to all relevant staff.

The operating policy and procedures were standardised, and included the title, reference number, approvers and scope of the policy, but did not include reference to the document owner. Obsolete versions of the policy and procedures were retained, but were removed from possible access by staff.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
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 provided a dedicated room for the facilitation of Mental Health Tribunals, and had adequate administrative and staffing resources in place to support the Tribunals process. Staff accompanied residents to Mental Health Tribunal hearings, as required, in order to provide support and assistance.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in March 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints in the approved centre. Where complaints could not be addressed by this nominated person, they were escalated in accordance with the approved centre’s policy.

A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person, was publicly displayed, and it was detailed within the resident information booklet. Residents, their representatives, family, and next of kin were notified of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, electronically via e-mail, by telephone, and through feedback or suggestion forms.
All complaints were handled promptly, appropriately and sensitively. All complaints, regardless of the frequency of reporting, were investigated fully, with due process applied. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of any complaint being made. Minor complaints were also documented.

The complainant was informed promptly of the outcome of the complaint investigation, and details of the appeals process were made available to them. This was documented. The complainant’s satisfaction or dissatisfaction with the investigation findings was documented.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003, and the Freedom of Information Act 1997 and 2003.

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 monitoring pillars.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in May 2019. The approved centre also had a Patient Safety Statement, which was last reviewed in February 2019, and a site-specific safety statement, which was last reviewed in January 2019. The risk management policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at the three-monthly health and safety meetings, in order to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had not been completed to identify opportunities for improving risk management processes, and no audit measures were taken to address risks against the time frames identified on the risk register.
Evidence of Implementation: The requirements for the protection of children and vulnerable adults within the approved centre was appropriate and implemented as required. The risk management procedures in place actively reduced identified risks to the lowest practicable level of risk.

Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes. Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at resident admission, transfer, discharge, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Individual risk assessments were completed in advance of and during resident seclusion, physical restraint, and specialised treatments such as electro-convulsive therapy, as relevant.

Structural risks were still present in the approved centre since the previous inspection, however a phased plan was in place for the removal of ligature points. All residents were risk assessed for self-harm and suicide risk. Residents deemed to be of high risk were either placed in a high observation unit, or other appropriate interventions, such as supervision, were used to mitigate those risks.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT at their regular meetings. A record of these reviews was maintained, and actions were recommended. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided in the summaries was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, and monitoring 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. The certificate was displayed prominently in a public area of the approved centre. Conditions relating to the certificate of registration were documented and prominently displayed.

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 59: The Use of Electro-Convulsive Therapy

Section 59

(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
   (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
   (b) where the patient is unable to give such consent –
      (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
      (ii) the programme of therapy is also 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.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated November 2018. It contained protocols that were developed in line with best international practice, including:

- ECT protocols developed in line with best international practice
- How and where the initial and subsequent doses of Dantrolene are stored
- Management of cardiac arrest
- Management of anaphylaxis
- Management of malignant hyperthermia

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room, and adequately-equipped treatment and recovery rooms. High-risk patients were treated in a rapid intervention area. Materials and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist (CP), and a consultant anaesthetist, had overall responsibility for ECT management and anaesthesia, respectively. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

A written record of the assessment of capacity to consent to ECT was detailed in the patients’ clinical file. It indicated that the patient was unable to give informed consent for ECT. A Form 16: Electroconvulsive Therapy Involuntary Patient (adult) – Unable to Consent was completed, and placed in the clinical file, and a copy was sent to the Mental Health Commission within five days. ECT was administered in accordance with section 59(1)(b) of the Mental Health Act 2001.

Prior to the administration of the eighth ECT treatment session, a medical entry within the clinical file documented that the resident had regained capacity in the context of receiving ECT however, a comprehensive capacity assessment was not documented. Information was provided on the likely adverse effects of ECT however, other appropriate information such as the nature, description, purpose, benefits of ECT treatment and alternatives to ECT were not given by the consultant psychiatrist to enable the
patient to make a decision on consent. Written consent to subsequent ECT treatments and anaesthesia was not obtained from the patient.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and/or next of kin, a current mental state examination, and the assessment completed before and after each ECT treatment. A pre anaesthetic assessment was documented in the clinical file and included medical history, a physical exam, any dental issues, duration of fasting, relevant haematology and biochemistry investigations, an ECG and chest x-ray. The assessment did not include a detailed medication history and failed to record a penicillin allergy which affected the patient. An anaesthetic risk assessment was recorded by the anaesthetist. ECT was administered by a constant, current, brief pulse ECT machine.

The ECT record which was completed after each treatment was placed in the clinical file. The ECT register was completed on conclusion of the ECT programme. All pre and post ECT assessments were detailed and recorded in the clinical file. Adverse events during or following ECT were addressed in full and were recorded. The reasons for continuing or discontinuing ECT were recorded. Copies of all cognitive assessments were place in the clinical file.

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

a) Appropriate information on ECT was not given by the consultant psychiatrist to enable the patient to make a decision on consent for each treatment session of ECT, 2.1.

b) Information was not provided both orally and in writing or any other form in a clear and simple language that the patient could understand, 2.3.

c) A comprehensive assessment of capacity by the consultant psychiatrist was not completed, 3.3.

d) Consent was not obtained in writing for the eighth and ninth ECT treatment session, including anaesthesia.

e) A detailed medication history including allergies or previous anaesthetic difficulties was not recorded, 7.3(c).
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 been reviewed annually and was dated November 2018. The policy addressed all of the elements of this rule, including the following:

- Those authorised to carry out seclusion.
- The provision of information to the patient.
- 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. This was documented.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Seclusion facilities were maintained and cleaned to ensure respect for resident dignity and privacy, as far as practicable. All furniture and fittings were of a design and quality that would not endanger patient safety. The seclusion rooms were not used as bedrooms. Male residents in seclusion did not have access to toileting and washing facilities in a manner that was consistent to their rights to privacy and dignity.

The clinical files of three patients who had been placed in seclusion were inspected. In all cases, seclusion was initiated by a registered medical practitioner (RMP) or a registered nurse (RN). The consultant psychiatrist was always notified as soon as practicable of the use of seclusion, and this was documented in the clinical files and seclusion register. Where seclusion was initiated by an RN, an assessment, including a risk assessment, was completed prior to seclusion taking place. The episodes of seclusion were recorded in the clinical files. Two of the seclusion episodes were clearly recorded in the seclusion register however, in one episode, the time of seclusion ending was not clearly documented. The seclusion register was signed by the responsible consultant within 24 hours. In all cases reviewed, a medical review of the patient took place no later than 4 hours after the commencement of the episode of seclusion.
The number and duration of episodes of seclusion had decreased since the last inspection, and the structural issues relating to the lack of due privacy and dignity were in the process of being addressed.

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

a) Male patients in seclusion did not have access to toilet and washing facilities in a manner which safeguarded their privacy and dignity, 8(1).

b) One episode of seclusion was not clearly and accurately recorded in the seclusion register, 9(2).
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 of that medicine 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.

A Form 17: Treatment without Consent, Administration of Medicine for More than 3 Months – Involuntary Patient (Adult) had been completed within the required three-month time frame, and a copy of same was in the patient’s clinical file. The Form 17 contained the following information:

- The name of medication prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effect of the medications.
- Details of the discussion with the patient in terms of the nature, purpose, and effects of the medication.
- Any views expressed by the patient.
- Supports provided to the patient in relation to the discussion and their decision-making process.
• Authorisation by a second consultant psychiatrist.

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/had not been reviewed annually and was dated January 2019. It addressed the following:

- The provision of information to the resident.
- Who could initiate and implement physical restraint.
- The process for protecting a child who had been physically restrained.

Training and Education: There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

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

Evidence of Implementation: Three clinical files were inspected in relation to the use of physical restraint. In all cases, the use of physical restraint was in exceptional circumstances, and as a last resort, where each resident posed an immediate threat to themselves, or to others. In all three cases, physical restraint was initiated by a registered medical practitioner (RMP), a registered nurse (RN) or a member of the multidisciplinary team (MDT), in accordance with the policy on physical restraint, with a designated staff member acting as the lead.

In all cases, the consultant psychiatrist was notified of the event as soon as was reasonably practicable. The episodes of physical restraint were not prolonged beyond the period absolutely necessary. Gender sensitivity was demonstrated during each episode. An RMP completed a medical examination of the each resident no later than three hours after the start of an episode. Each episode of physical restraint was recorded in the relevant resident’s clinical file.

All residents were informed of the reasons, likely duration, and circumstances leading to the discontinuation of physical restraint. In two cases, the next of kin were informed of the use of physical restraint, and in the third case, they were not informed, but the justification for this was documented in the resident’s clinical file. Special considerations were given when restraining a resident who was known to have experienced physical or sexual abuse. In all cases, staff of the same gender as the resident were present at all times during the episode of physical restraint, and each of the residents were afforded the opportunity to discuss the episode with members of the MDT involved in each of their care as soon as was reasonably practicable. Each episode of restraint was reviewed by members of the MDT and documented in the residents’ clinical files no later than two working days after each episode.

The approved centre was non-compliant with this code of practice because there was no written record that staff had read and understood the training policy, 9(2)(b).
Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in September 2016. It addressed the following:

- The individual risk assessment of each child being admitted to the approved centre.
- Family liaison, parental consent, and confidentiality.
- The identification of the person responsible for notifying the Mental Health Commission of the admission of a child.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: Nine children were admitted to the approved centre since the last inspection. The Mental Health Commission was notified within 72 hours of the admission of each child. All of the children were admitted on a short-term basis. Consent to admission was obtained from each child’s next of kin. Age-appropriate facilities and a programme of activities appropriate to the children’s age and abilities were not provided.

There were provisions in place to ensure the safety of each child, to respond to each child’s special needs as a young person in an adult setting, and to ensure that the children’s right to have their views heard. Each child had a single room in a gender segregated unit, and was nursed on a one-to-one basis. Children had their rights explained, and were provided with information about their stay on the ward in a form and language that they could understand. The Mental Health Commission toolkit was given to each child and explained as appropriate to their next of kin.

Copies of the Child Care Act 1991, Children Act 2001, and the Children First guidelines were made available to relevant staff, and all staff who had contact with the children had undergone Garda vetting. Relevant staff acknowledged gender sensitivity, and observation arrangement were provided as considered clinically appropriate. Advice from the Child and Adolescent Mental Health Service was available to the approved centre where necessary. Appropriate visiting arrangements were made for each child’s family.

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

a) There were nine admissions of children under the age of 18 years, and age-appropriate facilities and a programme of activities were not provided, 2(5)(b).

b) Age appropriate advocacy services were not available, 2(5)(g).
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated November 2018. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated suite for the delivery of ECT, which had a private waiting area, an adequately equipped treatment room, and an adequately equipped recovery room. High-risk voluntary patients were treated in a rapid-intervention area. Materials and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. At least two registered nurses were in the ECT suite at all times during a treatment session, one of whom was a designated ECT nurse.

A named consultant psychiatrist (CP) had responsibility for ECT management. The clinical file of one voluntary patient who was receiving ECT was examined. The CP assessed his or her capacity to consent to treatment, and this was documented in their clinical file. The voluntary patient was deemed capable to consent to receiving ECT. Appropriate information on ECT was given by the CP to enable the resident to make a decision on consent, including the nature of the treatment, a description of the process, the purpose and intended benefits of ECT, and confirmation that the resident would be offered alternative treatment if they later decided to withhold consent.

Information provided on likely adverse effects of ECT, including risk of cognitive impairment and amnesia and other potential side-effects were included on the clinical file and consent form. In addition, information provided both orally and in writing was in clear and simple language that the residents could understand, as documented in the clinical file. The voluntary resident was informed of their right to raise questions at any time. Consent was obtained for each individual ECT treatment session, including anaesthesia.

A programme of ECT was prescribed by the responsible CP, and was recorded in the clinical file. The prescription detailed the reasons for using ECT, the alternative therapies that were considered or which had proved ineffective, documentation of discussions with the resident’s next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was also documented in the clinical file. ECT was administered by a constant,
current, brief pulse ECT machine. The ECT record was completed and signed by the relevant registered medical practitioners, as were the post-ECT assessments, all of which were placed in the clinical file. Copies of all cognitive assessments were placed in the clinical file.

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

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer and discharge. The admission and discharge policy was last reviewed in February 2019; the policy in relation to transfer of a resident was last reviewed in May 2017, and the policy in relation to the transfer of a patient to another approved centre, including the Central Mental Hospital was last reviewed in September 2017. All policies combined included all of the policy-related criteria of the code of practice.

Training and Education: There was no documentary evidence that relevant staff had read and understood the admission, transfer, or 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: The clinical file of one resident was inspected in detail in relation to the admission process. The resident’s admission was on the basis of a mental illness or a mental disorder. An admission assessment had been completed, which included: the presenting problem; past psychiatric history; family history; social and housing circumstances; current mental state; risk assessment; and any other relevant information, such as the resident’s work situation, education and dietary requirements. A full physical examination was also undertaken. However, the admission assessment did not contain medical history, or a record of current and historic medication.

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

Discharge: The file of one resident who was discharged was inspected. The discharge was coordinated by the resident’s key worker. The discharge plan included: the estimated date of discharge; documented communication with the relevant medical practitioner; and a follow-up plan. A discharge meeting was attended by the resident, the key worker and relevant members of the multi-disciplinary team. The resident’s discharge plan included a psychiatric and psychological needs; a current mental state assessment; a comprehensive risk assessment and risk assessment and risk management plan; the resident’s social housing and informational needs. A comprehensive discharge summary was issued within 14 days, and included details of the resident’s: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow up arrangements; names and contact details for key people to follow-up; and risk issues, such as signs of relapse. A timely follow-up appointment was also scheduled.

The approved centre was non-compliant with this code of practice for the following reasons:
a) There was no evidence that relevant staff had read and understood the admission, transfer or discharge policies, 9.1.

b) The admission assessment did not record medical history, 15.3.

c) The admission assessment did not record current and historic medication, 15.3.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 19 General Health

<table>
<thead>
<tr>
<th>Reason ID : 10000525</th>
<th>All six-monthly general health assessments did not document BMI, waist circumference, smoking status, nutritional status, or dental health, 19(1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Since the initial report was issued, all clients who were admitted for 6 months or more have had their six months physical checks completed by their team. Each team was written to by the Clinical Director.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>We will keep regular checks on clients approaching six months and ensure six monthly physicals are completed by the team and verified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000526</th>
<th>For residents on antipsychotic medication, an annual assessment including glucose regulation, blood lipids, heart health via an electrocardiogram exam, or prolactin levels was not undertaken for all residents, 19(1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>As with physicals all six monthly reviews have been achieved and completed for fasting bloods, glucose, blood</td>
</tr>
</tbody>
</table>
lipids, prolactin levels and ECG.

| Preventative Action | As with physicals we will keep a regular check on clients approaching 6 months and ensure these bloods tests and ECG's are completed and results recorded in six monthly proforma | Ongoing quarterly audits to be performed by the medical team. | Ongoing and no barriers identified | 31/01/2020 | Clinical Director |
### Regulation 16: Therapeutic Services and Programmes

**Reason ID : 10000534**

Residents in the high dependency unit were not provided with therapeutic services and programmes which were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning, 16(2).

<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>This non compliance was discussed at the Approved Centre Governance meeting. The recovery team have established a therapeutic programme for residents requiring High Observation. A programme of activities is timetabled and on display and all attendance is documented in resident’s personal file.</td>
<td>The recovery team will maintain record of assessment and attendance at the programme and record maintained in clinical file.</td>
<td>Currently programme delivered twice a week. Plans to extend to a 5 day week if resources are allocated.</td>
<td>31/01/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ongoing review and assessment of the therapeutic programme for residents requiring High Observation. A list of programmes is on display outside High Observation.</td>
<td>The recovery team will maintain record of assessment and attendance at the programme and record maintained in clinical file.</td>
<td>Expansion of the current therapeutic programme is dependant on an increase in resources.</td>
<td>31/01/2020</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID : 10000535</th>
<th>Some areas of the premises were not maintained in good structural and decorative condition, 22(1)(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
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<tr>
<td>Corrective Action</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000536</th>
<th>There were a large number of high risk ligature points evident which had not been minimised. The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and well-being of residents, 22(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
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<tr>
<td>Corrective Action</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID: 10000537</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, Children First and Therapeutic Management of Violence and Aggression, 26(4). Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<tbody>
<tr>
<td>Heads of Discipline have reviewed Training records, identified individual staff training deficits and will facilitate staff attendance at training in order to achieve full compliance. Training is a standing item on the agenda of all team meetings in the department and disciplines. All staff are encouraged to fulfill their professional obligation to complete mandatory training.</td>
</tr>
<tr>
<td>Audit of Training records at scheduled MDT Training Planning meeting which is held every quarter.</td>
</tr>
<tr>
<td>Availability of staff to attend training with due regard to safe rostering.</td>
</tr>
<tr>
<td>31/12/2019</td>
</tr>
<tr>
<td>Heads of discipline.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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</thead>
<tbody>
<tr>
<td>Heads of Discipline have reviewed Training records, identified staff training deficits and facilitate staff attendance at Training.</td>
</tr>
<tr>
<td>Audit of Training records at scheduled MDT Training Planning meeting held every quarter.</td>
</tr>
<tr>
<td>This is reliant on the availability of staff to attend training with due regard to safe rostering. Of note is the evident improvement in increased compliance, see attached.</td>
</tr>
<tr>
<td>31/12/2019</td>
</tr>
<tr>
<td>Heads of disciplines.</td>
</tr>
</tbody>
</table>
Male residents in seclusion were required to cross the hallway to use the bathroom and shower facilities.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan to develop new seclusion room suite to incorporate ensuite facility - see attached</td>
<td>Schedule of works attached</td>
<td>Funding is approved, see schedule of works attached.</td>
<td>30/06/2020</td>
<td>Estates and Head of Mental Health Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Time-bound</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Plan to develop new seclusion room suite to incorporate ensuite facility - see attached</td>
<td>Schedule of works attached</td>
<td>Funding is approved, see schedule of works attached.</td>
<td>30/06/2020</td>
<td>Estates and Head of Mental Health Service</td>
</tr>
</tbody>
</table>
### Regulation 06 Food Safety

<table>
<thead>
<tr>
<th>Reason ID: 10000540</th>
<th>No food temperatures were recorded in line with food safety recommendations for 4 days within a 2 week period, 6(2)(c).</th>
</tr>
</thead>
</table>

<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>Meeting was held with relevant staff and food safety policy was discussed. Actions were agreed to safeguard against a recurrence of this non compliance. Designated members of staff have been assigned to the kitchen roster.</td>
<td>Weekly monitoring of records undertaken</td>
<td>Achieved</td>
<td>31/07/2019</td>
<td>CNM111 and ADON</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing monitoring of records. Ongoing agenda item at MTA meetings with DOP management.</td>
<td>Weekly monitoring of records undertaken</td>
<td>Ongoing</td>
<td>31/07/2019</td>
<td>CNM111 and ADON</td>
<td></td>
</tr>
</tbody>
</table>
### Code of Practice on Admission, Transfer and Discharge to and from an approved centre

**Reason ID : 10000519**  
**There was no evidence that relevant staff had read and understood the admission, transfer or discharge policies, 9.1.**

<table>
<thead>
<tr>
<th></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><strong>Corrective Action</strong></td>
<td>All relevant disciplines updating policy signature banks as appropriate.</td>
<td>All heads of disciplines will ensure their staff have read and signed relevant policy documents. The MDT policy group will inform all heads of disciplines of all updates and reviews of policies.</td>
<td>Achievable- no barriers identified</td>
<td>31/01/2020</td>
<td>All heads of disciplines.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ongoing review of signatures and policy updates</td>
<td>Audits</td>
<td>Achievable - no barriers identified</td>
<td>31/01/2020</td>
<td>All heads of disciplines.</td>
</tr>
</tbody>
</table>

**Reason ID : 10000520**  
**The admission assessment did not record medical history, 15.3. The admission assessment did not record current and historic medication, 15.3.**

<table>
<thead>
<tr>
<th></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><strong>Corrective Action</strong></td>
<td>All medical teams have been asked to review their admissions and to complete the admission proformas.</td>
<td>Audits to be carried out on a monthly basis by the relevant NCHDs.</td>
<td>Achievable - no barriers identified- ongoing</td>
<td>31/01/2020</td>
<td>Clinical Director</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>All teams are to review the admission proformas on an ongoing weekly basis and to complete the proformas.</td>
<td>Reviewed on a weekly basis by the Sector Consultants.</td>
<td>Achievable and ongoing</td>
<td>31/01/2020</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

**Reason ID : 10000521**  
**The admission assessment did not record current and historic medication, 15.3.**

<table>
<thead>
<tr>
<th></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><strong>Corrective Action</strong></td>
<td>All medical teams have been asked to review their admission proformas.</td>
<td>Audited on a monthly basis by the relevant NCHDs.</td>
<td>Achievable.</td>
<td>31/01/2020</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Preventative Action Details</td>
<td>Reviewed</td>
<td>date</td>
<td>signed by</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<tr>
<td>admissions and to complete the admission proformas.</td>
<td>All medical teams are to review the admission proformas on an ongoing weekly basis and to complete the proformas</td>
<td>Reviewed weekly by Consultant group. yes - no barriers and ongoing</td>
<td>31/01/2020</td>
<td>Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>
**Code of Practice on the Use of Physical Restraint in Approved Centres**

**Reason ID : 10000524**

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All relevant disciplines will read and sign the policy.</td>
<td>Heads of relevant disciplines will instruct their staff to read and sign the policy to ensure compliance.</td>
<td>Achievable- no barriers</td>
<td>31/01/2020</td>
<td>Heads of Disciplines.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable and ongoing</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Heads of relevant disciplines will instruct their staff to read and sign the policy.</td>
<td>Heads of relevant disciplines will instruct their staff to read and sign the policy to ensure compliance.</td>
<td>Achievable and ongoing</td>
<td>31/01/2020</td>
<td>Heads of Discipline.</td>
</tr>
</tbody>
</table>
There were nine admissions of children under the age of 18 years, and age-appropriate facilities and a programme of activities were not provided, 2(5)(b).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A programme of age appropriate educational activities in so far as practicable, has been devised with the assistance of the specialised adolescent unit...Supporting documentation is attached. When a child &lt; 18 years requires admission, all the CAMHS Units are contacted on call and a referral made urgently. We only admit where there is no bed available and risks dictate that urgent admission is needed while awaiting a bed. The CAMHS Consultants continue caring for the child for the duration of the admission.</td>
<td>The ADON undertakes an audit after each child admission and there is a section to check if child availed of suitable activities. See attached documentation.</td>
<td>Achievable but if a parent does not provide consent this may be a barrier.</td>
<td>28/11/2019</td>
<td>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>On going Audit of child admissions to the Approved centre will be undertaken monthly.</td>
<td>The ADON undertakes an audit/check after each child admission (see attached checklist).</td>
<td>Achievable - audit is undertaken after each admission- no barrier</td>
<td>28/11/2019</td>
<td>Clinical Director and ADON</td>
<td></td>
</tr>
</tbody>
</table>

Reason ID : 10000533

Age appropriate advocacy services were not available, 2(5)(g).
| Corrective Action | No definite service is available. Linn Dara and Galway CAMHS Unit are piloting a service and we will continue to check with them. | Executive Clinical Director will keep in contact with Linn Dara and Galway CAMHS. | Availability of this service | 31/12/2019 | Executive Clinical Director |
| Preventative Action | No definite service is available. Linn Dara and Galway CAMHS Unit are piloting a service and we will continue to check with them. | Executive Clinical Director will keep in contact with Linn Dara and Galway CAMHS. | Availability of this service | 31/12/2019 | Executive Clinical Director |
## Rules Governing the Use of Electro-Convulsive Therapy

### Reason ID: 10000527

Appropriate information on ECT was not given by the consultant psychiatrist to enable the patient to make a decision on consent for each treatment session of ECT, 2.1.

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) A review and discussion of the case in question took place at the Consultants Peer Group Meeting on Friday 12th July, 2019 to identify learning from the case. (2) Procedure was discussed at induction for new NCHD’s and existing NCHD’s on 12th July, 2019. Mental Health Commission Rules Governing the use of ECT and copy of Form 16 was sent to all Consultants and NCHD’s (date &amp; copy of email attached). (3) The Clinical Director contacted the RCP for the case who has since left the service to share learning from the case. Copy of rules and form 16 also send to RCP. (4) Educational Session on ECT at Consultants Peer Group on 13th August, 2019 and same repeated at NCHD Educational meeting on same day. (5) A section on the process is now included in NCHD Induction Manual (copy attached). (6) Cases for ECT are now discussed at the Consultants meeting and process revised. (7) We will repeat the ECT session at the Peer Group</td>
<td>Achieved</td>
<td>Achieved and no barriers</td>
<td>31/08/2019</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Preventative Action</td>
<td></td>
<td></td>
<td>Achievable - no barriers</td>
<td>31/08/2019</td>
<td>Clinical Director</td>
</tr>
<tr>
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</tr>
<tr>
<td>six monthly on same date as the NCHD ECT Induction.</td>
<td>Audit performed at the completion of each programme of ECT.</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Reason ID : 10000528**

Information was not provided both orally and in writing or any other form in a clear and simple language that the patient could understand, 2.3.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>(1) A review and discussion of the case in question took place at the Consultants Peer Group Meeting on Friday 12th July, 2019 to identify learning from the case. (2) Procedure was discussed at induction for new NCHD's and existing NCHD's on 12th July, 2019. Mental Health Commission Rules Governing the use of ECT and copy of Form 16 was sent to all Consultants and NCHD's (date &amp; copy of email attached). (3) The Clinical Director contacted the RCP for the case who has since left the service to share learning from the case. Copy of rules and form 16 also send to RCP. (4) Educational Session on ECT at Consultants Peer Group on 13th August, 2019 and same repeated at NCHD Educational meeting on same day. (5) A section on the process is now included in NCHD Induction Manual (copy attached). (6) Cases for ECT are now discussed at Audits</td>
<td>Achievable - no barriers</td>
<td>31/08/2019</td>
<td>Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>
the Consultants meeting and process revised. (7) We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction.

**Preventative Action**

We will repeat the ECT session at the Peer Group six monthly on same date the NCHD ECT Induction. The ECT Documentation Pack has been updated so that the information required for capacity assessment and consent are visible opposite each individual ECT consent.

Audit performed at the completion of each programme of ECT.

Achievable - no barriers

31/08/2019

Clinical Director

**Reason ID : 10000529**

A comprehensive assessment of capacity by the consultant psychiatrist was not completed, 3.3.

<table>
<thead>
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<tbody>
<tr>
<td>(1) A review and discussion of the case in question took place at the Consultants Peer Group Meeting on Friday 12th July, 2019 to identify learning from the case. (2) Procedure was discussed at induction for new NCHD's and existing NCHD's on 12th July, 2019. Mental Health Commission Rules Governing the use of ECT and copy of Form 16 was sent to all Consultants and NCHD's (date &amp; copy of email attached). (3) The Clinical Director contacted the RCP for the case who has since left the service to share learning from the case. Copy of rules and form 16 also send to RCP. (4) Educational Audits performed on completion of each programme of ECT.</td>
<td>Achievable- no barriers</td>
<td>31/08/2019</td>
<td>Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>
Session on ECT at Consultants Peer Group on 13th August, 2019 and same repeated at NCHD Educational meeting on same day. (5) A section on the process is now included in NCHD Induction Manual (copy attached). (6) Cases for ECT are now discussed at the Consultants meeting and process revised. (7) We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction. (8) The medication section has been increased in the new proforma.

| Preventative Action | We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction. ECT form will be reviewed at Consultants meeting. | Audit performed on completion of each programme of ECT. | Achievable - no barriers- Ongoing | 31/08/2019 | Clinical Director |

**Reason ID : 10000530**

Consent was not obtained in writing for the eighth and ninth ECT treatment session, including anaesthesia.

| Corrective Action | (1) A review and discussion of the case in question took place at the Consultants Peer Group Meeting on Friday 12th July, 2019 to identify learning from the case. (2) Procedure was discussed at induction for new NCHD's and existing NCHD's on 12th July, 2019. Mental Health Commission Rules Governing the use of ECT and copy of Form 16 was sent to all Consultants and NCHD's (date | Medical assessment will take place prior to every application of ECT. | Achieved | 31/08/2019 | Clinical Director |
& copy of email attached). (3) The Clinical Director contacted the RCP for the case who has since left the service to share learning from the case. Copy of rules and form 16 also send to RCP. (4) Educational Session on ECT at Consultants Peer Group on 13th August, 2019 and same repeated at NCHD Educational meeting on same day. (5) A section on the process is now included in NCHD Induction Manual (copy attached). (6) Cases for ECT are now discussed at the Consultants meeting and process revised. (7) We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction.

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction. ECT form will be reviewed at Consultants meeting.</th>
<th>Ongoing review after each application of ECT.</th>
<th>Achievable- no barriers</th>
<th>30/11/2019</th>
<th>Clinical Director</th>
</tr>
</thead>
</table>

Reason ID: 10000531
A detailed medication history including allergies or previous anaesthetic difficulties was not recorded, 7.3(c).

| Corrective Action | (1) A review and discussion of the case in question took place at the Consultants Peer Group Meeting on Friday 12th July, 2019 to identify learning from the case. (2) Procedure was discussed at induction for new NCHD's and existing NCHD’s on 12th July, | To be reviewed on a weekly basis at Consultants Meeting. | Achieved | 31/08/2019 | Clinical Director |
2019. Mental Health Commission Rules Governing the use of ECT and copy of Form 16 was sent to all Consultants and NCHD’s (date & copy of email attached). (3) The Clinical Director contacted the RCP for the case who has since left the service to share learning from the case. Copy of rules and form 16 also send to RCP. (4) Educational Session on ECT at Consultants Peer Group on 13th August, 2019 and same repeated at NCHD Educational meeting on same day. (5) A section on the process is now included in NCHD Induction Manual (copy attached). (6) Cases for ECT are now discussed at the Consultants meeting and process revised. (7) We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction. (8) The medication section has been increased in the new proforma.

<table>
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<tr>
<th>Preventative Action</th>
<th>Action</th>
<th>Achievable</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will repeat the ECT session at the Peer Group six monthly on same date as the NCHD ECT Induction. Medications Section has been increased in the new proforma.</td>
<td>Audits to be performed at the end of each programme of ECT.</td>
<td>Achievable- no barriers</td>
<td>31/08/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

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

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

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

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