Elm Mount Unit, St. Vincent's University Hospital

**ID Number:** AC004

**2019 Approved Centre Inspection Report (Mental Health Act 2001)**

Elm Mount Unit, St Vincent's University Hospital
Elm Park
Dublin 4

**Approved Centre Type:**
- Acute Adult Mental Health Care
- Psychiatry of Later Life
- Other: Eating Disorder In-Patient

**Most Recent Registration Date:**
1 March 2017

**Conditions Attached:**
None

**Registered Proprietor:**
HSE

**Registered Proprietor Nominee:**
Ms Martina Behan, General Manager, CHO East Mental Health Services

**Inspection Team:**
Carol Brennan-Forsyth, Lead Inspector
Martin McMenamin
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**Inspection Date:**
8 - 10 May 2019

**Inspection Type:**
Unannounced Annual Inspection

**Previous Inspection Date:**
10 - 13 July 2018

**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Date of Publication:**
Tuesday 17 December 2019

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**2019 COMPLIANCE RATINGS**

**REGULATIONS**
- Compliant: 2
- Non-compliant: 10
- Not applicable: 19

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

**CODES OF PRACTICE**
- Compliant: 2
- Non-compliant: 1
- Not applicable: 2
RATINGS SUMMARY 2017 – 2019

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

**Chart 1 – Comparison of overall compliance ratings 2017 – 2019**

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

**Chart 2 – Comparison of overall risk ratings 2017 – 2019**
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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

Elm Mount Unit was an approved centre situated in St. Vincent’s University Hospital, Elm Park, Dublin 4. It was run in partnership between the HSE and the St. Vincent’s Healthcare Group. The approved centre provided mental health in-patient treatment and care to people living in the Community Healthcare Organisation (CHO) 6, namely the Dublin South East area. Elm Mount Unit was a 39-bed unit divided into three areas: Elm Mount Upper, an acute admission unit; Elm Mount Lower, a sub-acute admission unit; and a specialist Psychiatry of Old Age (POA) unit. Three beds in Elm Mount Lower, were dedicated to residents with eating disorders.

Over the past three years there has been some improvement in compliance with regulations, rules and codes of practice: 63% compliance in 2017, 59% in 2018 and 67% in 2019. The approved centre has been non-compliant with Regulation 15: Individual Care Plan and the Code of Practice on Physical Restraint for four consecutive years. Both of these non-compliances have been rated high risk on this inspection. There were eight compliances with regulations that were rated excellent.

Conditions to registration

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

Safety in the approved centre

- The storage of medication was carried out in a safe manner.
- Food safety requirements, under Regulation 6: Food Safety, were met.

However:

- There were a number of deficits in the medication prescription and administration record (MPARs) which could potentially lead to medication errors, including lack of documentation of allergies or sensitivities to any medications.
- Not all health care staff received mandatory training in fire safety, Basic Life Support, Professional Management of Violence and Aggression (PMAV), the Mental Health Act 2001 and Children First.
- The closure of another service had resulted in an increased number of residents admitted to the approved centre with advanced stage dementia, and the limited space within the POA unit was identified by staff as a contributory factor in the increased number of reported violence, harassment, and aggression incidents.
- The shower room flooring surfaces were observed as being a hazard, as the flooring surface was uneven and this hazard was not minimised at the time of inspection.
• Ligature points were identified throughout the approved centre, and a schedule of works to address ligatures had been implemented to minimise these risks.

**Appropriate care and treatment of residents**

- Individual care plans (ICPs) were discussed, agreed where practicable, and drawn up with the participation of residents and their representatives, family, and next of kin, as appropriate.
- Therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents. They were evidence-based, and included Tai Chi, reflections and relaxation, art therapy, brunch club, a sports club and gardening. In upper and lower Elm Mount, therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies.
- The approved centre was compliant with the Code of Practice on Admission, Transfer and Discharge.

However:

- Of the ten ICPs inspected, three did not have appropriate goals, and one did not specify care and treatment interventions. Four of ten ICPs inspected did not specify resources, as required.
- No dedicated facilities or therapy rooms were available in the Psychiatry of Old Age unit for individual or group therapies.
- The skill mix of staffing was insufficient to meet residents’ needs. A psychologist was assigned to the eating disorder unit but no psychologist was assigned to residents in the remaining 36 beds. Psychologists from the community mental health multi-disciplinary teams responded to referrals. There was a shortage of social workers.
- The required six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively monitor general health. The assessment did not include Body Mass Index, waist circumference, smoking and nutritional status, and dental review in all cases. In the case of two residents on antipsychotic medication, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually.

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

- Where residents shared a room, bed screening ensured that their privacy was not compromised.
- Overall, the approved centre was observed to be clean, hygienic, and free from offensive odours.
- Seclusion was not used in the approved centre.

However:

- All bedrooms did not have a blind on the observation panel, and windows were without curtains. Not all windows had opaque glass, meaning the some bedrooms in the approved centre compromised residents’ privacy by being overlooked by public areas.
- Poor ventilation remained an ongoing issue, particularly in the Electro Convulsive Therapy (ECT) suite which had been identified as a risk. There were plans to install an air conditioning unit in this suite, but this had not been installed at the time of inspection.
- There was not enough space for residents to move about in the Psychiatry of Old Age (POA) unit, or in the external courtyard. The doors of the POA unit were locked, impeding residents moving about in outdoor spaces.
- Despite a programme of general and decorative maintenance, the approved centre was not kept in a good state of repair; there were scuff marks on internal walls, the laminate covering at the bottom of the internal doors was chipped and the laminate flooring was disintegrating in some of the bedrooms, shower rooms and en suites.
- One external courtyard which was littered with discarded cigarette butts and used coffee cups.
• Physical restraint was not carried out in accordance with the Code of Practice on Physical Restraint.

**Responsiveness to residents’ needs**

• There were visitor’s areas and visiting times were appropriate and clearly displayed.
• Information about the approved centre, residents’ diagnoses and medication was available in written form.
• There was a nominated person responsible for dealing with all complaints and a consistent and standardised approach was implemented for the management of all complaints.

However:

• Minor verbal complaints were not recorded in the complaints log. These comments were required to be logged in the complaints log as per HSE Complaints, Comments, and Compliments Policy.
• There was no recreational activities programme available within the approved centre. Recreational activities for residents was entirely dependent on availability of staff in the Psychiatry of Old Age unit. These elderly residents did not always have access to nurse led activities, which was necessary for the resident group profile.

**Governance of the approved centre**

• There was shared governance between the HSE Community Healthcare East and St. Vincent’s Healthcare Group. For the greater part, clinical governance was under the management of the HSE Community Healthcare East. Executive management and local operations management meetings took place every month. Issues such as department updates, quality and patient safety, finance, human resources, and health and safety were discussed at these forums.
• The quality and safety committee met every six weeks. Minutes of these meetings were made available to the inspection team and included agenda items such as risk register updates, review of incident reports, and quality improvement plans.
• The policy review group updated relevant policies. The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines.
• Actions to manage risks were identified and the risk register recorded timeframes for the completion of these actions. Processes for risk escalation from the local risk register were in place.
• The approved centre had an audit plan in place. Audits were undertaken by nursing staff and other members of the multi-disciplinary team. Some audits had been completed fully and others lacked a clear action plan.
• Not all health care staff received mandatory training in fire safety, Basic Life Support, Professional Management of Violence and Aggression (PMAV), the Mental Health Act 2001 and Children First. A variety of non-mandatory training courses were also available to staff, and management facilitated and encouraged staff members to engage in higher education programmes.
• Resident involvement in service improvement was principally achieved via community meetings and feedback obtained by ‘Your Service, Your Say’ surveys. Not all complaints, however, had been documented in the approved centre’s complaints log.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had developed checklists to improve processes for physical restraint and searches.

2. The approved centre had introduced a weekly ‘policy dissemination day’ to make staff aware of changes to policies.

3. A HSE best practice guideline self-assessment group had been established in the approved centre.

4. The approved centre’s Information Booklet had been updated with regards to the admission and discharge processes.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Elm Mount Unit was an approved centre situated in St. Vincent’s University Hospital, Elm Park, Dublin 4. The unit was a partnership venture between the HSE and the St. Vincent’s Healthcare Group. The approved centre, which opened in 2005, provided mental health in-patient treatment and care to people living in the Community Healthcare Organisation (CHO) 6, namely the Dublin South East area. Elm Mount Unit was a 39-bed unit divided into three distinct areas.

Elm Mount Upper, located on the ground floor level, accommodated up to 20 residents. It was an acute admission unit that comprised shared bedroom accommodation and six single rooms. The shared accommodation consisted of three- and four-bed rooms for both male and female residents. The approved centre’s Electro-Convulsive Therapy (ECT) Suite was located within Elm Mount Upper. A specialist Psychiatry of Old Age (POA) unit was located adjacent to Elm Mount Upper and accommodated up to six residents. Accommodation comprised two single and two double bedrooms.

Elm Mount Lower was located in the lower ground floor and accommodated up to 13 residents. It was a sub-acute admission unit and comprised two five-bed shared rooms and three single rooms. There were three in-patient beds in Elm Mount Lower, dedicated to residents with eating disorders.

The occupational therapy department was located on the lower ground floor. It comprised group rooms, an activities kitchen, and offices. There were consulting rooms and an outpatient facility in this area, which was located around a bright and pleasant central glass atrium with planting and seating areas suitable for visits. This could be viewed from the ground floor reception area of Elm Mount Upper.

Overall, the approved centre was observed to be clean, hygienic and free from offensive odours, with the exception of one toilet area and an external courtyard. Poor ventilation remained an ongoing issue for the approved centre, particularly the ECT Suite. There were plans to install an air conditioning unit within the ECT suite; this had not been installed at the time of inspection.

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><strong>Number of registered beds</strong></td>
<td><strong>39</strong></td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td><strong>32</strong></td>
</tr>
<tr>
<td>Number of detained patients</td>
<td><strong>13</strong></td>
</tr>
<tr>
<td>Number of wards of court</td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>Number of children</td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
3.2 Governance

There was shared governance between the HSE Community Healthcare East and St. Vincent’s Healthcare Group. For the greater part, clinical governance was under the management of the HSE Community Healthcare East. Executive management meetings took place every second month. Issues such as department updates, quality and patient safety, finance, human resources, and health and safety were discussed at these forums. The minutes were reviewed and relevant issues were discussed by the senior management who documented actions and outcomes.

The quality and safety committee met every six weeks. Minutes of these meetings were made available to the inspection team and included agenda items such as risk register updates, review of incident reports, and quality improvement plans.

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

Actions to manage risks were identified and the risk register recorded timeframes for the completion of these actions. Processes for risk escalation from the local risk register were in place.

The approved centre had an audit plan in place. Audits were undertaken by nursing staff and other members of the multi-disciplinary team. Some audits had been completed fully and others lacked a clear action plan.

The number and skill mix of nursing staffing was sufficient to meet resident needs. At the time of the inspection, there was no designated psychologist working in the approved centre. Access to psychology was by referral. The social work department highlighted staff shortages in the approved centre. Not all health care staff received mandatory training in fire safety, Basic Life Support, Professional Management of Violence and Aggression (PMAV), the Mental Health Act 2001 and Children First. A variety of non-mandatory training courses were also available to staff, and management facilitated and encouraged staff members to engage in higher education programmes.

Resident involvement in service improvement was principally achieved via community meetings and feedback obtained by ‘Your Service, Your Say’ surveys. Not all complaints, however, had been documented in the approved centre’s complaints log. This issue was raised with clinical staff at the time of inspection.

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>
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</thead>
<tbody>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 13: Searches</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 the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As no resident had been mechanically restrained since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

The inspection team met with seven residents. They were generally complimentary of the care and treatment in the approved centre. In most cases, residents interviewed were appreciative of the accommodation and the food in the approved centre. Residents in the Psychiatry of Old Age unit mentioned that there were too many chips and scrambled eggs on the current menus. Negative comments received by the inspection team were followed up with management from the approved centre, specifically in relation to complaints.

Five completed service user experience questionnaires were returned to the inspection team. The questionnaires included very positive comments regarding support from staff. On a scale of 1-10 with 1 being poor and 10 being excellent, residents rated 7, 9 and 10 for their overall experience of the care and treatment in the approved centre.
6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Executive Clinical Director
- Clinical Director
- General Manager
- Area Director of Nursing
- Head of Service, Mental Health
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2 x 3
- Acting Occupational Therapy Manager
- Assistant Director of Nursing
- Mental Health Act Administrator
- Mental Health Engagement Lead
- Principal Social Worker
- Community Mental Health Social Worker

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. Discussions took place regarding referrals to other multi-disciplinary team members and the approved centre’s complaints processes. It was confirmed that finance had been secured for an air conditioning unit for the ECT suite and it was expected to be installed in the not so distant future.
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 April 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. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: The identifiers used were person specific, and did not include room number or physical location in the approved centre. Two resident identifiers were used when administering medication, medical investigations and providing other healthcare services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The use of appropriate identifiers and alerts for same or similarly named residents was also evident in the approved centre.

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per Food Pyramid. Residents had at least two choices for meals. Hot and cold drinks were offered to residents regularly, and a source of safe, fresh drinking water was available to residents at all times. Hot meals were provided on a daily basis.

For residents with special dietary requirements, an evidence-based nutrition tool was used. Weight charts were implemented, monitored, and acted upon for residents, where appropriate. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindications with medication. Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was 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 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 April 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 recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. Appropriate protective equipment, including Personal Protective Equipment (PPE), where required, was used during the catering process, and there was suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, and serving of food. Food was cooked off-site and transported to the approved centre. Food temperature logs were maintained and monitored daily by an appointed supervisor in order to support hygiene and food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned as per the regular schedule. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in April 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.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate to the resident and considered the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans. Residents had an adequate supply of individualised clothing.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in April 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: Residents had their own wardrobe and bedside locker which could not be locked. New wardrobes were being installed at the time of inspection, which would not be lockable either. The residents had access to lockers in a secure room, which could be accessed through nursing staff. In this regard, secure facilities were provided for the safe-keeping of the resident’s monies, valuables, personal property, and possessions, as necessary. Residents were encouraged to leave valuables at home or to be given to family for safe keeping. A property folder was maintained in the approved centre, and the resident could access this. Records were signed by two staff for monies up to 50 euros and upwards. Other amounts could be sent to the main hospital safe. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan, or in accordance with the approved centre’s policy.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: Residents in Elm Mount Upper and Elm Mount Lower had access to appropriate recreational activities, including television, radio, books, DVDs, puzzles, crosswords, games, and painting materials. Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities.

Residents in Elm Mount Upper did not have access to nurse-led recreational activities; however, they were accompanied off the unit by staff, where applicable, and there was an exercise bike on the unit. In the lower part of the approved centre, nurse-led recreational activities, such as card making, word wheel, and a gentle exercise group, were dependant on staff availability. There was also a foosball table in the quiet room. Opportunities were provided for indoor and outdoor exercise and physical activity, and communal areas were provided that were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file, as appropriate.

Residents in the Psychiatry of Old Age unit did not always have access to nurse-led activities, which was necessary for the resident group profile.

The approved centre provided access to recreational activities on weekdays and during the weekend. However, information was not provided to residents on recreational activities in all three units, and there was no recreational activities programme available within the approved centre, as they were completely dependent on staffing levels. In this regard, recreational activities provided by the approved centre were not appropriately resourced.

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

a) Residents in the Psychiatry of Old Age unit did not always have access to nurse-led activities, which was necessary for the resident group profile.

b) There was no recreational activities programme available within the approved centre.

c) Information was not provided to residents on recreational activities in all three units.
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 April 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 facilitating residents in the practice of their religion, as set out in the policy.

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

Evidence of Implementation: Residents’ rights to practice were facilitated within the approved centre insofar as was practicable. There was a church that operated as a multi-faith room on the hospital grounds which residents could access following the appropriate risk assessment process. Residents had access to multi-faith chaplains. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was 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 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.
(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.
(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.
(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.
(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.
(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

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

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

Evidence of Implementation: Visiting times were clearly displayed throughout the approved centre, and were also stated within the information booklet for residents and visitors. Visiting times were appropriate and reasonable, with specific reference to protected meal times, and restrictions on visiting early in the morning. If applicable, names of restricted visitors would be recorded. Visiting areas were provided throughout the approved centre, and directly outside the approved centre. While there was no identified visiting room, staff stated on inspection that such would be provided if requested, or if a child was visiting. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied by an adult at all times to ensure their safety, and this was communicated to all relevant individuals publicly.

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

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet via Wi-Fi, and telephone. In this respect, most residents had their own mobile devices. The approved centre provided a tablet that residents could access where necessary. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication, and documented in their individual care plan. The clinical director, or a senior staff member designated by the clinical director, only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and the received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, and residents were informed by those implementing the search of what is happening during the search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted.
Searches were implemented with due regard to the resident’s dignity, privacy, and gender, and at least one of the staff members conducting the search was of the same gender as the resident being searched. A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who attended at the search. Policy requirements were implemented when illicit substances were found as a result of a search, and searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in April 2017. The policy addressed requirements of the Judgement Support Framework, with the exception of the process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere, for example for general health care services.

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Systems analysis was undertaken in the event of a sudden or unexpected death in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: One clinical file of a resident who had died suddenly in the approved centre was inspected. The clinical file evidenced that the death was managed in accordance with legal requirements. The sudden death of a resident was managed in accordance with the resident’s religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. There was no evidence to suggest that support for other residents and staff had been provided.

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, monitoring, and evidence of implementation pillars.
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 April 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. Not all clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: Ten ICPs were inspected. All ICPs inspected were each recorded in one composite set of documents. The ICPs were developed by the MDT following a comprehensive resident assessment within seven days of admission. This assessment included the following: medical, psychiatric, and psychosocial history; medication history and current medications being taken; current physical health assessment; detailed risk assessment; social, interpersonal, and physical environment-related issues; communication abilities; and educational, occupational, and vocational history. ICPs were discussed, agreed where practicable, and drawn up with the participation of residents and their representatives, family, and next of kin, as appropriate.

Of the ten ICPs inspected, three did not have appropriate goals, and one did not specify care and treatment interventions. Four of ten ICPs inspected did not specify resources, as required. In terms of the ICPs being reviewed by the full complement of the MDT, the occupational therapist (OT) was not present for the review of certain care plans. In addition, ICPs were not always updated following interventions of the social worker, contravening the requirement for ICPs to be updated following review of changing needs, condition, circumstances, and goals. Residents had access to their ICPs and were kept informed of any changes and offered a copy of their ICP, including any reviews, and this was documented. When a resident declined or refused a copy of their ICP, this was recorded, including the reason, if given.

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

a) Three of ten ICPs inspected did not specify appropriate goals.
b) One ICP inspected did not specify care and treatment.
c) Four of ten ICPs inspected did not specify specific resources.
d) ICPs were not always updated following interventions by members of the MDT.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in April 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 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: Therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. They were evidence-based, and included Tai Chi, reflections and relaxation, art therapy, brunch club, a sports club and gardening. The therapeutic services and programmes provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

There was a weekly therapeutic programme that included art which was displayed in the approved centre; social work or psychology were not included in this programme. Adequate and appropriate resources and facilities were not fully available to provide therapeutic services and programmes, as there were not enough staff in the Social Work Department; therefore, they could not provide programmes in all parts of the approved centre. The Social Work team delivered a psycho education programme specifically for those attending/receiving supports from the Eating Disorder Team. In upper and lower Elm Mount, therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. No dedicated facilities or therapy rooms were available in the Psychiatry of Old Age unit.

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 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in October 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 was inspected. Communication records with the receiving facility were documented and available on inspection, including agreement of resident receipt prior to transfer. Documented consent of a resident to transfer was available, or justification as to why consent was not received. Full and complete written information for residents was transferred when they moved from the approved centre to another facility, and information was sent in advance or accompanied the resident upon transfer to a named individual.

The following information was issued, with copies retained, as part of the transfer documentation: a letter of referral, a list of current medications, the resident transfer form, and required medication for the resident during the transfer process. In cases of emergency transfer, communications between the approved centre and the receiving facility was documented and followed up with written referral. In addition, a checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility.

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 general health policy and medical emergencies policy were last reviewed in June 2018. The policies and procedures 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 policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents’ uptake 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: There was an emergency trolley and staff had access to an Automated External Defibrillator (AED) at all times, and weekly checks were completed in this regard.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Two residents were in the approved centre for six months and had required and received a six monthly general health assessment. Their two clinical files inspected showed that the two residents received appropriate general health care interventions in line with their individual care plans. Residents’ general health needs were monitored and assessed at least every six months.

While both residents had received a six-monthly general health assessment, the assessment itself was not adequately completed. Both files inspected evidenced that each resident had received a physical examination. The six-monthly general health assessment records evidenced the following discrepancies on inspection:

- Residents’ Body Mass Index, weight, and waist circumference was not checked and recorded in one case.
- Smoking status was not documented in one case.
- Nutritional status: diet and physical activity, including sedentary lifestyle, was not documented in one case.
- A dental health assessment was not documented in one case.

Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.
Both residents were on antipsychotic medication, they received an annual assessment of their glucose levels and of their heart function though an electrocardiogram. This was documented. Residents’ blood lipids, and prolactin levels were not documented in both cases despite the requirement for these checks to take place annually.

Residents had access to national screening programmes appropriate to age and gender. Information was provided to any resident regarding the national screening programmes available through the approved centre. Residents had access to a smoking cessation programme.

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

a) The six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively assess each resident’s general health needs. The assessment did not include Body Mass Index, waist circumference, smoking and nutritional status, and dental review in all cases, 19(1)(b).

b) For two residents on antipsychotic medication, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually, 19(1)(b).
Regulation 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:
   (a) details of the resident’s multi-disciplinary team;
   (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
   (c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
   (d) details of relevant advocacy and voluntary agencies;
   (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of information to residents. The policy was last reviewed in April 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed 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: There was an information booklet available which included information on housekeeping arrangements, including personal property and mealtimes, visiting times, the complaints process, details of relevant advocacy and voluntary agencies, and residents’ right. Residents were provided with details of their multi-disciplinary team. Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, provision of such information might be prejudicial to the resident’s well-being. In this respect, the justification for restricting information regarding a resident’s diagnosis was documented in the clinical file, and there was no evidence of any restriction.

Medication information sheets as well as verbal information were provided in a format that was appropriate to resident needs. Medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. The information in the documents provided by the approved centre on inspection was evidence-based, and appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as 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 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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents were called by their preferred name. The general demeanour of staff and the manner in which staff addressed and communicated with residents was respectful. Staff were discrete when discussing the resident’s condition or treatment needs and sought the resident's permission before entering their room, as appropriate. In relation to layout and furnishings, where residents shared a room, bed screening ensured that their privacy was not compromised. In addition, residents were facilitated to make private phone calls.

The locks on the inside of the single bedroom doors could only be locked with a generic staff key. All bedrooms did not have a blind on the observation panel, and windows were without curtains. Not all windows had opaque glass, meaning the some bedrooms in the approved centre compromised residents’ privacy by being overlooked by public areas. The noticeboard in the approved centre contained residents’ full names and this was visible from outside the nursing office through the glass.

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

a) One noticeboard in the approved centre contained the residents’ full names.

b) The observation panel on one bedroom was not fitted with a curtain, blind, or opaque glass.
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 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 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 completed to identify opportunities for improving the premises.

Evidence of Implementation: Communal areas within both Elm Mount Upper and Elm Mount Lower were appropriately sized. The closure of another service, however, resulted in an increased number of residents with advanced stage dementia, and the limited space within the unit was identified by staff as a contributory factor in the increased number of reported violence, harassment, and aggression incidents. Consequently, this risk was escalated and conveyed to the Senior Management Team.

On inspection, temperature was an issue in the approved centre due to a lack of ventilation. Poor ventilation remained an ongoing issue, particularly in the Electro Convulsive Therapy (ECT) suite which had been identified as a risk. There were plans to install an air conditioning unit in this suite, but this had not been installed at the time of inspection. No issues were identified with noise levels and acoustics, as private and communal areas were suitably sized and furnished to mitigate this potential issue. The lighting in the communal rooms suited the needs of residents and staff, and was sufficiently bright and positioned to facilitate reading and other such activities. Appropriate signage and sensory aids were provided to support resident orientation needs. There was not sufficient space for residents to move about in the...
Psychiatry of Old Age (POA) unit, or in the external courtyard. The doors of the POA unit were locked, impeding residents moving about in outdoor spaces.

The shower room flooring surfaces were observed as being a hazard, as the flooring surface was uneven and this hazard was not minimised at the time of inspection. Ligature points were identified throughout the approved centre, and a schedule of works to address ligatures had been implemented to minimise these risks. In relation to maintenance, the approved centre was not kept in a good state of repair; there were scuff marks on internal walls, the laminate covering at the bottom of the internal doors was chipped and the laminate flooring was disintegrating in some of the bedrooms, shower rooms and en suites. There was, however, a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained in this respect.

Overall, the approved centre was observed to be clean, hygienic, and free from offensive odours, with the exception of one external courtyard which was littered with discarded cigarette butts and used coffee cups. Additionally, one toilet room had toilet paper and posters on the floor. Requests to alter temperatures were submitted to the maintenance department, meaning that heating could not be safely controlled in the resident’s own room in compliance with health and safety guidance and building regulations.

There was a sufficient number of toilets and showers for residents in the approved centre, and all resident bedrooms were appropriately sized to address the resident needs. The psychiatry for older age unit did not, however, have dedicated therapy and examination rooms. One lift was available to residents with mobility issues, and there was a designated laundry room in Elm Mount Lower.

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

a) The premises was not clean and maintained in good decorative condition. The external courtyard was littered with discarded cigarettes butts and used coffee cups. One toilet was untidy, some doors were chipped, the laminate flooring was disintegrating and some walls were marked, 19 (1)(a).

b) The premises was not adequately ventilated, such as in the ECT suite, 19 (1)(b).

c) The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and patients, and the safety and well-being of residents, as ligatures had not been minimised to the lowest practicable level, 19 (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 April 2017. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.
- The process for reviewing medication.

Training and Education: 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 the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARs were reviewed during inspection. Two MPARs did not record allergies or sensitivities to medications. One MPAR did not record the frequency of administration, including the minimum dose of interval for as required medication. Two MPARs did not record all medications administered to residents. All entries in the MPARs were legible, and written in black indelible ink. In most cases, there were weekly reviews of medication, particularly where there was a significant change in the resident’s care or condition, and this was documented in the clinical file. Prescriptions were not altered where a change was required, and where an alteration was required in the medication order, the medical practitioner had rewritten the prescription.

Medicinal products were administered in accordance with the directions of the prescriber, and any advice provided by that resident’s pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration, and expired medications were not administered. Direction to crush medication was only accepted from the resident’s medical practitioner. An instruction to crush medication, however, was not prescribed for one resident in the Psychiatry of Old Age (POA) unit, resulting in no documented reason being given for such an action. Additionally, in one case the medical practitioner did not document in the MPAR that the medication was to be crushed. It was noted on inspection that the medication fridge temperature was not monitored in Elm Mount Lower.
Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. Also, food and drink were not stored in areas used for holding medication. The medication trolleys remained locked at all times and was secured in locked rooms. While no schedule 2 drugs were stored in the approved centre, schedule 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. Stock lists were in place for the name and dose of medication, and generous stock levels were observed in relation to the quantity of medication in the approved centre. Medications that were no longer required, which were past their expiry date or have been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

a) A record of allergies or sensitivities to any medications was not completed in two MPARS, 23 (1).
b) Two MPARs did not record all medications administered to the resident, 23(1). 
c) The frequency of one PRN dose was not stated in one record, 23 (1). 
d) In one MPAR, directions to crush medications was not prescribed and there was no documented reason given, 23 (1).
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 April 2017. The policy statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- Response to sharps and needles.
- Availability of staff vaccinations and immunisations.
- Support provided to staff following exposure to infectious diseases.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The process for transferring responsibility from one staff member to another.
- The required qualifications of training personnel.

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.

<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 (44)</td>
<td>44</td>
<td>83%</td>
<td>45</td>
<td>85%</td>
<td>31 62%</td>
</tr>
<tr>
<td>Consultant Psychiatrist (13)</td>
<td>13</td>
<td>100%</td>
<td>13</td>
<td>100%</td>
<td>12 93%</td>
</tr>
<tr>
<td>Medical (17)</td>
<td>10</td>
<td>59%</td>
<td>7</td>
<td>41%</td>
<td>7 41%</td>
</tr>
<tr>
<td>Occupational Therapist (3)</td>
<td>3</td>
<td>100%</td>
<td>1</td>
<td>33%</td>
<td>1 33%</td>
</tr>
<tr>
<td>Social Worker (7)</td>
<td>7</td>
<td>100%</td>
<td>7</td>
<td>100%</td>
<td>6 86%</td>
</tr>
</tbody>
</table>

NON-COMPLIANT
Quality Rating Requires Improvement
Risk Rating HIGH
Evidence of Implementation: There was an organisational chart to identify 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 the staff on duty at any one time during the day and night, was maintained in the approved centre.

The number and skill mix of staffing was insufficient to meet resident needs. A psychologist was assigned to the eating disorder unit but no psychologist was assigned to residents in the remaining 36 beds. Psychologists from the community mental health multi-disciplinary teams responded to referrals. The social work department highlighted staff shortages in the approved centre.

Staff in the approved centre had the appropriate qualifications to carry out their occupational duties. Additionally, an appropriately qualified staff member was on duty and in charge at all times, which was documented. The approved centre was developing a staffing plan at the time of inspection.

Not all health care professionals were trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001, or Children First. Staff were trained in line with the assessed needs of the resident group profile and of individual residents. This included manual handling, dementia care, end of life care, and risk management. All staff training was documented, and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education, and these opportunities were effectively communicated to all relevant staff and adequately supported. In-service training was completed by appropriately trained and competent individuals. In addition, facilities and equipment were available for staff in-service education and training.

The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elm Mount Upper</td>
<td>CNM1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM3</td>
<td>0</td>
<td>Shared between 3 units</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.9</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td></td>
<td>Shared between 3 units</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td></td>
<td>By referral</td>
</tr>
</tbody>
</table>
The approved centre was non-compliant with this regulation for the following reasons:

a) The skill mix of staffing was insufficient to meet residents’ needs as there was a shortage of social workers, 26 (2).

b) Not all staff had up-to-date training in fire safety, Basic Life Support, management of violence and aggression and Children First training, 26 (4).

c) Not all the 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 in relation to the maintenance of records. The policy was last reviewed in December 2017. The policy addressed all of the 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 required resident record creation and content.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.
- The destruction of records.

Training and Education: 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. 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: Not all records were secure, up to date, in good order, and constructed, maintained and used in accordance with national guidelines and legislative requirements. It was noted on inspection that occasionally, when there was a re-admission, the admission documentation was filed among the progress notes. Some clinical files were large in size and weight, resulting in the outer cover being torn. Loose pages were also observed in three of the five clinical files inspected, with Electro Cardiogram (ECG) printout and correspondence not properly secured. Resident records were reflective of the residents’ status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence.

Records were written legibly in black, indelible ink and were readable when photocopied, and entries were factual, consistent, and accurate and did not contain jargon. Each entry included the date, used the 24-hour clock, and was followed by a signature, but the approved centre did not maintain a record of all
signatures used in the resident record. All entries made by student nurses and clinical training staff were countersigned by a registered nurse or clinical supervisor. Errors made in the records of the approved centre did not adhere to the required protocol for making corrections. Two appropriate resident identifiers were recorded on all documentation, and where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title.

Records were appropriately secured throughout the approved centre from loss or destruction.

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

a) Loose pages were not secured in three of the five files inspected, with ECG printout and correspondence not properly secured, 27 (1).

b) A number of clinical files were large in size and weight, resulting in the outer cover being torn, 27 (1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in April 2017. It 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, including service users, as appropriate. The operating policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines, and were appropriately approved. Operating policies and procedures were communicated to all relevant staff. The format of policies and procedures was standardised and included the title of the policy and procedure, reference number and revision of the policy and procedure, document owner, and approvers.

Relevant policies were reviewed within three years for compliance with this regulation. Where generic policies, such as complaints and staffing were used, the approved centre had a written statement to this effect, which was reviewed at least every three years. Generic policies used were appropriate to the approved centre and the resident group profile.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved did not meet all criteria of the Judgement Support Framework under the training and education pillar.
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 August 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 private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation. The quality assessment was rated 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 in relation to the management of complaints, which was last reviewed in December 2017. The policy addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed. 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 and a consistent and standardised approach was implemented for the management of all complaints. The approved centre’s complaints process was well publicised and accessible to residents and their representatives. All complaints, whether written or oral, were investigated promptly and handled appropriately and sensitively. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan (ICP). Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy. Minor verbal complaints were not recorded in the complaints log. These comments were required to be logged in the complaints log as per HSE Complaints, Comments, and Compliments Policy.
Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy, and this was documented in the complaints log. Time frames were provided in the approved centre for responding to the complaint following the initial receipt of such, the investigation period for complaints, and the required resolution of complaints. In addition, the complainant’s satisfaction, or dissatisfaction, with the investigation findings was documented.

The approved centre was non-compliant with this regulation because not all complaints dealt with by the nominated person were recorded in the complaints log, 31 (6).
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 April 2017. The policy addressed all of the requirements of the Judgement Support Framework, with the exception of capacity risks relating to the number of residents in the approved centre.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. 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 least quarterly to determine compliance with the approved centre’s risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and the risk management procedures actively reduced identified risks to the lowest practicable level. Clinical, health and safety, and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register, as appropriate. Structural risks, however, including ligature points, were not effectively mitigated or removed, despite the fact that ligatures were identified throughout the approved centre, and the audit in this regard was available to the inspection team.

Individual risk assessments were completed prior to and during physical restraint, Electro Convulsive Therapy (ECT), at admission, and resident transfer and discharge. The requirements for the protection of
children and vulnerable adults within the approved centre were appropriate and implemented as required. Residents and their representatives, however, were not fully involved in the individual risk management process.

The approved centre used the National Incident Management System (NIMS) in order to record and risk-rate incidents, which were subsequently reviewed by the multi-disciplinary team (MDT) at their regular meeting. The approved centre provided a six-monthly summary of all incidents to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan which specified responses by the approved centre staff to possible emergencies and also incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because ligature points were not effectively mitigated, 32 (1).
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 the foyer of the approved centre.

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

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 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
May 2018. It contained protocols that were developed in line with best international practice, including:

- 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: All staff involved in ECT were trained in line with best international practice,
and had appropriate training and education in Basic Life Support techniques. The approved centre had a
dedicated ECT suite with a private waiting room, and adequately equipped treatment room and recovery
room. High-risk patients were treated in the general hospital theatre, and there was a facility for
monitoring EEG on two channels, as the approved centre had recently acquired a new machine. ECT
machines were regularly maintained and serviced, and a record of such was maintained, as well as
confirmation of servicing. Materials and equipment in the ECT suite, including emergency drugs, were in
line with best international practice. Up-to-date protocols for the management of cardiac arrest,
anaphylaxis, and malignant hyperthermia, were prominently displayed. The named consultant psychiatrist
had overall responsibility for ECT management, and the named consultant anaesthetist had overall
responsibility for anaesthesia.

At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.
One clinical file was inspected. An ECT information booklet was given to the patient by the consultant
psychiatrist to make a decision on consent, including the nature and treatment of ECT, a description of
the process, and the purpose of the treatment. Information was also provided on likely adverse effects of
the treatment, and information was given verbally and in writing, in clear simple language that the patient
could understand. Subject to the urgency of clinical circumstances, the patient was given 24 hours to
reflect on the information if they so wished. Consent to each programme of ECT, including anaesthesia,
was in written form and included confirmation that the patient had been given the relevant information.
A programme of ECT was only prescribed by the responsible consultant psychiatrist, and the prescription
for ECT was recorded in the patient’s clinical file, including the reason for the decision to use ECT, and alternative therapies that were considered or proved ineffective.

A cognitive assessment was completed before each programme of ECT, and the patient’s clinical status was assessed before and after each ECT treatment session. Ongoing monitoring of the patient’s cognitive functioning took place throughout the ECT programme. The consultant psychiatrist, in conjunction with the patient, reviewed the patient’s progress and potential need for continuation of the treatment.

The approved centre was compliant with this rule.
9.0 Inspection Findings – Mental Health Act 2001

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

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

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

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

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

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

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

INSPECTION FINDING

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In both cases, there was documented evidence that the consultant psychiatrist had undertaken a capacity assessment, which measured the patients’ ability to consent to receiving treatment. Following the capacity assessment, both patients were deemed unable to consent to receiving treatment.

A Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been appropriately completed in both cases. The form evidenced the following:

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

All forms were completed within the appropriate timeframe.

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

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

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

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

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

INSPECTION FINDINGS

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

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is 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. The record was not available to the inspector.

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

Evidence of Implementation: Three cases of physical restraint were inspected. It was used in rare, exceptional circumstances and was in the best interests of the resident, where the resident posed immediate threat of harm to themselves or others. Physical restraint was only used after all alternative interventions to manage the resident’s unsafe behaviour had been considered. Physical restraint was based on a risk assessment, and cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint. In one case of physical restraint, the consultant psychiatrist or duty consultant psychiatrist was not notified as soon as was practicable, as the psychiatry registrar only was notified. Additionally in this case of physical restraint, the Clinical practice form was not signed by the consultant psychiatrist within 24 hours.

In two cases of physical restraint, it was not documented in the clinical file that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of the treatment. It was not documented in the clinical file in all three cases that where the resident had capacity, the next of kin or representative was notified. In two of the three cases inspected, staff were not aware of the relevant considerations in individual care plans pertaining to the resident’s requirements or needs in relation to the use of physical restraint. In one case inspected, physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode.

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

a) Not all staff involved in physical restraint had signed that they had read and understood the policy, 9.2 (b).

b) The clinical practice form was not signed by the consultant psychiatrist within 24 hours, 5.7 (c).

c) In two cases of physical restraint, it was not documented in the clinical file that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of the treatment, 5.8.

d) In three cases, it was not documented in the clinical file that the next of kin or representative was notified, 5.9 (a).
e) In one case inspected, physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode, 9.3.

f) In two episodes, it was not documented that the staff member responsible for leading in the physical restraint of a resident did not monitor the head and airway of the resident, 5.2.

g) In one episode, it was not recorded in the clinical file that the consultant psychiatrist or duty consultant psychiatrist was notified, 5.3.
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 May 2018. It contained protocols that were developed in line with best international practice, including:

- 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. Material and equipment required for ECT, including emergency drugs, were in line with best international practice. The ECT machine was 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 had responsibility for ECT management, and a named consultant anaesthetist had overall responsibility for anaesthesia. A registered designated ECT nurse was in the ECT suite at all times.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient’s capacity to consent to receiving treatment, and this was documented in the patient’s clinical file. The patient was deemed capable of consenting to the receipt of ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the patient to make a decision on consent. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that each patient could understand. The patient was informed of his/her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia. The consultant psychiatrist administered a capacity assessment on the voluntary patient.

A programme of ECT for the voluntary patient 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 voluntary patient and next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded.
The ECT record, which was completed after each treatment, was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. All pre and post ECT assessments were detailed and recorded in the clinical file. The reasons for continuing or discontinuing ECT was recorded. 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 policy was dated January 2018, and transfer and discharge were dated October 2017.

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

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

Admission: An assessment was completed at admission, and admission was on the basis of mental illness or mental disorder. Additionally, an initial key worker system was in place. Assessment included the following: presenting problem; past psychiatric history; family history; medical history; current and historic medication; social and housing circumstances, where relevant; current mental health state; risk assessment; full physical examination; and any other relevant information, such as work situation, education, and dietary requirements. Upon admission, the resident’s family member, carer, or advocate were involved with the consent of the resident.

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

Discharge: The discharge plan included the estimated date of discharge, documented communication with the relevant general practitioner or primary care team, a follow-up plan, and a reference to early warning signs of relapse and risks. The discharge meeting was attended by the resident in question, a key worker, relevant members of the multi-disciplinary team and, with the consent of the resident, a family member, carer, or advocate. The discharge assessment addressed psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs, and informational needs. Discharge was coordinated by a key worker, and a preliminary summary in this regard was sent to the general practitioner, community mental health team (CMHT), or primary care team within three days. A comprehensive discharge summary was issued within 14 days.

Discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow up arrangements, names and contact details of key people for follow-up, as appropriate, and risk issues such as any signs of relapse. Where appropriate, a family member, carer, or advocate was involved in the discharge process. Additionally, a timely follow-up appointment within a one week time frame was put in place, relevant to any recent history of self-harm or a possible suicide risk.

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

#### Regulation 9: Recreational Activities

<table>
<thead>
<tr>
<th>Reason ID: 10000428</th>
<th>Residents in the Psychiatry of Old Age unit did not always have access to nurse led activities, which was necessary for the resident group profile.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Approved centre provides access to recreational activities appropriate to the resident group profile. At present recreational activities are provided by existing nursing staff on a day to day basis. However these activities are dependent on the staffing level within the approved centre. To address this concern a review of all resources available will be undertaken by relevant HODs, with a view to ensuring consistency in the resource available.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>There is on-going monitoring of the range of recreational activities provided, to ensure the range of activities are meeting the requirements of the resident group profile.</td>
</tr>
</tbody>
</table>
Reason ID : 10000429

There was no recreational activities programme available within the approved centre. Information was not provided to residents on recreational activities in all three units.

<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>Records of participation, engagement and outcomes achieved in recreational activities are maintained within the resident's ICP and clinical file. A list of all recreational activities provided within the service is available to resident in the approved centre information booklet. A timetable of recreational activities is displayed within the approved unit.</td>
<td>Audit feedback from resident review recreational activities timetable</td>
<td>Achieved</td>
<td>10/10/2019</td>
<td>PIC CNM2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-going monitoring of recreational activities provided, to ensure they meet the assessed needs of resident.</td>
<td>Review</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>PIC CNM2</td>
</tr>
</tbody>
</table>
Analysis is completed to identify opportunities for improvement.
### Regulation 19: General Health

**Reason ID: 10000438**

The six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively assess each resident's general health needs. The assessment did not include Body Mass Index, waist circumference, smoking and nutritional status, and dental review in all cases, 19(1)(b).

<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>A new Physical Health Assessment Form will be introduced to meet the documentation requirements in relation to general health assessments include Body Mass Index, waist circumference, smoking and nutritional status, and dental review. Records /Checklist are available demonstrating residents completed general health checks and the associated results, including records of any clinical testing.</td>
<td>Audit</td>
<td>Achievable</td>
<td>30/11/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Documented review to ensure all service users have a six-monthly review</td>
<td>Regular analysis</td>
<td>Achievable</td>
<td>30/11/2019</td>
</tr>
</tbody>
</table>
Reason ID: 10000439

For two residents on antipsychotic medication, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually, 19(1) (b).

<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>A new Physical Health Assessment Form will be introduced to meet the documentation requirements in relation to general health assessments include blood lipids, and prolactin levels for residents on antipsychotic medication. Records / Checklist are available demonstrating residents completed general health checks.</td>
<td>Audit</td>
<td>Achievable</td>
<td>30/11/2019</td>
<td>NCHD Consultants</td>
<td></td>
</tr>
</tbody>
</table>

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<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>Six monthly general examination checklists introduced within the approved centre. All clinical files will be reviewed bi-monthly for the completion of general health needs reviews.</td>
<td>Regular analysis</td>
<td>Achievable</td>
<td>30/11/2019</td>
<td>NCHD</td>
<td></td>
</tr>
<tr>
<td>Reason ID : 10000440</td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
<td>Post-Holder(s)</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>In March 2018 an Architect was appointed to review ligature audits for the three Approved Centres in Community Healthcare East, including Elm Mount Unit and make recommendations in respect of remedial works required. The Architect appointed a specialist contractor to undertake works across the three approved centre sites on a phased basis over 2018 and 2019. The programme of works will be complete in Quarter 4 2019.</td>
<td>Visible</td>
<td>Achievable/realistic</td>
<td>30/11/2019</td>
<td>HSE Estates SVUH Estates General Manager ADON Clinical Director</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>2019 ligature audit completed in August 2019. HSE Estates will commence the process to appoint an Architect in Jan 2020 to make recommendations in</td>
<td>Through annual ligature audit</td>
<td>The feasibility of the remedial measures recommended will be considered by the Service in Consultation with HSE Estates/SVUH Estates/Architect/Contractor. Factors such as disruption to residents/scale of</td>
<td>31/12/2020</td>
<td>HSE Estates SVUH Estates General Manager ADON Clinical Director</td>
</tr>
</tbody>
</table>
respect of the next phase of remedial works required and appoint a specialist contractor to address ligature points with the budget available.

works/available funding etc. will require careful consideration as part of Phase 2 planning phase and may present as a barrier to implementation.
### Regulation 31: Complaints Procedures

**Reason ID: 10000441**

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<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>
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</tr>
<tr>
<td>The details of the complaints procedure and the nominated person for dealing with complaints are on display in a prominent position within the service. A consistent and standardised approach is implemented for the management of all complaints. All complaints are recorded in the Complain / Complement log book.</td>
<td>Audits of the complaints log</td>
<td>Achieved</td>
<td>30/06/2019</td>
<td>MDT complaint Manager</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
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</tr>
<tr>
<td>The nominated person for dealing with complaints maintains an up-dated complaints log. Review and analysis is completed to identify opportunities for improvement recognition, reporting and management of complaints</td>
<td>Audits of the complaints log and related records</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>MDT complaint Manager</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

#### Reason ID: 10000442

The premises was not clean and maintained in good decorative condition e.g. external courtyard was littered with cigarette butts and used coffee cups, one toilet was untidy, doors were chipped, laminate flooring was disintegrating and walls were marked, 19(1)a

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
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<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
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<tr>
<td>There is a system in place to audit the premises, including hygiene audit. A cleaning schedule is in place. The replacement of laminate flooring is approved and planned for 2019 along with the fitting of a wall scuff sheet, designed to minimise the marks created by trollys and cleaning machinery. A programme of regular touch up painting is carried out routinely by SVUH Estates (Maintenance).</td>
<td>Hygiene audit Visible flooring wall sheeting</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>HSE Estates SVUH Estates (Maintenance) General Manager ADON Clinical Director</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
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</tr>
<tr>
<td>A programme of routine maintenance and decoration of the premises is developed and implemented. Analysis is completed to identify opportunities to improve the premises.</td>
<td>Regular Analysis</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>HSE Estates SVUH Estates (Maintenance) General Manager ADON Clinical Director</td>
</tr>
<tr>
<td>Reason ID : 10000443</td>
<td>The premises was not adequately ventilated, e.g. ECT suite, 19(1)b</td>
<td></td>
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</tbody>
</table>
|----------------------|-----------------------------------------------------------------
| **Corrective Action**| *The approved centre noncompliance with inadequate ventilation in ECT suits addressed and resolved. Two Air-conditioning unit fitted in ECT suits in July 2019.* |
| Specific             | Measurable          | Achievable/Realistic | Time-bound | Post-Holder(s)                  |
|                      | Visible / Feedback  | Achieved             |            | HSE Estates                      |
|                      | from MDT            |                      | 31/07/2019 | SVUH Estates                     |
|                      |                      |                      |            | Registered Proprietor            |
|                      |                      |                      |            | ADON                              |
|                      |                      |                      |            | Clinical Director                 |

| **Preventative Action**| *Analysis is completed to identify opportunities to improve the premises. This is documented.* |
| Specific             | Measurable          | Achievable           | Time-bound | Post-Holder(s)                  |
|                      | Regular analysis    | Achievable           | 31/12/2019 | PIC                              |

| Reason ID : 10000444 | The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and patients, and the safety and well-being of residents, as ligatures had not been minimised to the lowest practicable level, 19 (3). |
|----------------------|-----------------------------------------------------------------
| **Corrective Action**| *In March 2018 an Architect was appointed to review ligature audits for the three Approved Centres in Community Healthcare East, including Elm Mount Unit and make recommendations in respect of remedial works required. The Architect appointed a specialist contractor to undertake works.* |
| Specific             | Measurable          | Achievable/Realistic | Time-bound | Post-Holder(s)                  |
|                      | Visible             | Achievable/realistic | 30/11/2019 | HSE Estates                      |
|                      |                     |                      |            | SVUH Estates                     |
|                      |                     |                      |            | General Manager                  |
|                      |                     |                      |            | ADON                              |
|                      |                     |                      |            | Clinical Director                 |
across the 3 approved centre sites on a phased basis over 2018 and 2019. The programme of works will be completed in Quarter 4 2019.

| Preventative Action | 2019 ligature audit completed in August 2019. HSE Estates will commence the process to appoint an Architect in Jan 2020 to make recommendations in respect of next phase remedial works required and appoint a specialist contractor to address ligature points within the budget available. | Through annual ligature audit | The feasibility of the remedial measures recommended will be considered by the Service in Consultation with HSE Estates/SVUH Estates/Architect/Contractor. Factors such as disruption to residents/scale of works/available funding etc. will require careful consideration as part of Phase 2 planning phase and may present as a barrier to implementation. | 31/12/2020 | HSE Estates SVUH Estates General Manager ADON Clinical Director |
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

**Reason ID : 10000445**

A record of allergies or sensitivities to any medications was not completed in two MPARS, 23 (1). Two MPARs did not record all medications administered to the resident, 23(1). The frequency of one PRN dose was not stated in one record 23(1). In one MPAR, directions to crush medications was not prescribed and there was no documented reason given, 23 (1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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<tbody>
<tr>
<td></td>
<td>Non-compliance with practices regarding ordering and prescribing of medications are addressed and rectified. Medication management process is monitored and reviewed according to evidence-based practice. Quarterly audits of medication prescription and administration records are undertaken and attached.</td>
<td>Quarterly audits</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>NCHD Consultants Audit Group</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All nursing and medical staff have read and understand the policies and procedures for medication management and this is 1. Review Weekly Checklist 2. Analysis is completed to identify opportunities for improvement of medication</td>
<td>Achievable</td>
<td></td>
<td>31/12/2019</td>
<td>NCHD Consultants Nursing</td>
</tr>
<tr>
<td>Management processes, and attached.</td>
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<tr>
<td>Nursing undertaking daily checks.</td>
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</tbody>
</table>
### Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID: 10000449</th>
<th>The skill mix of staffing was insufficient to meet residents' needs as there was a shortage of social workers, 26 (2).</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>Social Workers</td>
<td>Support people through their care journey, following people from the community into the approved centre. All Social Workers attend the inpatient and outpatient Multidisciplinary Team meetings and have responsibility to provide social work support, where there is an assessed need.</td>
<td></td>
<td>Achievable/realistic</td>
<td>31/12/2019</td>
<td>Principal Social Worker and Social Work Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessments</td>
<td>Completed in respect of staff shortages, for inclusion on the Risk Register.</td>
<td>On risk register</td>
<td>Achievable</td>
<td>06/11/2019</td>
<td>Principal Social Worker, Head of Service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000450</th>
<th>Not all staff had up-to-date training in fire safety, Basic Life Support, management of violence and aggression and Children First training, 26 (4). Not all the staff had up-to-date mandatory training in the Mental Health Act 2001, 26 (5).</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>Staff are provided with training to meet the assessed needs of residents within the approved centre.</td>
<td>Review training data base</td>
<td>Achievable</td>
<td>30/11/2019</td>
<td>HODs All staff</td>
<td></td>
</tr>
</tbody>
</table>
Training needs analysis completed and schedule for training developed and circulated within the approved centre. Please see the attachment. Training data base systems are maintained to recording and manage training.

| Preventative Action | Review and analysis is completed within the approved centre to identify opportunities to improve staff training process. Staffs are provided with protected time for completing HSELand e-Learning education and training. | Regular Review on staff training process | Achievable | 31/12/2019 | HODs All Staff |
### Regulation 15: Individual Care Plan

**Reason ID : 10000452**

Three of ten ICPs inspected did not specify appropriate goals. One ICP inspected did not specify care and treatment. Four of ten ICPs inspected did not specify specific resources. ICPs were not always updated following interventions by members of the MDT.

<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>Non-compliances with ICP process were addressed and rectified. Resident’s ICP’s have been reviewed and updated with appropriate goals for the resident. This is documented in the individual ICP’s. Introduced a new ICP form in the approved centre, since May 2019. ICP training session conducted for relevant MDTs. Audits of ICPs are carried out on a quarterly basis and improvements required are documented and implemented.</td>
<td>Quarterly Audit</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>MDT</td>
</tr>
</tbody>
</table>

| Preventative Action        | Local regulatory compliance working group established to identify opportunities to improve the | Analysis     | Achievable            | 31/12/2019  | MDT            |
|                            |                                                                                         |              |                      |             | Key Worker     |
Individual care planning process. The Key worker will undertake weekly check that all patients have a fully completed and up to date ICP (checklist attached). Identified gaps will be brought to the attention of the MDT.
### Regulation 21: Privacy

<table>
<thead>
<tr>
<th>Reason ID: 10000456</th>
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<tbody>
<tr>
<td>One noticeboard in the approved centre contained the residents' full names.</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
</tr>
<tr>
<td>Specific: At present noticeboards within the approved unit did not detail resident full names or other identifiable information.</td>
</tr>
<tr>
<td>Measurable: Visible / Audit</td>
</tr>
<tr>
<td>Achievable/Realistic: Achieved</td>
</tr>
<tr>
<td>Time-bound: 30/09/2019</td>
</tr>
<tr>
<td>Post-Holder(s): PIC</td>
</tr>
</tbody>
</table>

| **Preventative Action** |
| Specific: Observational audit and walk-through review is undertaken to ensuring resident privacy and dignity is met as set out in the policy |
| Measurable: Annual Audit / Regular Analysis |
| Achievable/Realistic: Achievable |
| Time-bound: 31/12/2019 |
| Post-Holder(s): Audit Group |

<table>
<thead>
<tr>
<th>Reason ID: 10000457</th>
</tr>
</thead>
<tbody>
<tr>
<td>The observation panel on one bedroom was not fitted with a curtain, blind or opaque glass.</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
</tr>
<tr>
<td>Specific: Non-compliance with resident privacy addressed and rectified. At Present, all observation panels on doors of bedrooms have blinds, curtains or opaque glass</td>
</tr>
<tr>
<td>Measurable: Visible</td>
</tr>
<tr>
<td>Achievable/Realistic: Achieved</td>
</tr>
<tr>
<td>Time-bound: 31/08/2019</td>
</tr>
<tr>
<td>Post-Holder(s): PIC</td>
</tr>
</tbody>
</table>

| **Preventative Action** |
| Specific: Observational audit and walk-through review is undertaken to ensuring resident privacy and dignity is met as set out in the policy |
| Measurable: Annual Audit / Regular Analysis |
| Achievable/Realistic: Achievable |
| Time-bound: 31/12/2019 |
| Post-Holder(s): Audit Group |
met as set out in the policy
### Regulation 27: Maintenance of Records

**Reason ID : 10000458**

<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>The Ward Clerk checks all patient files during the week to ensure that all patient notes are kept in one composite file and that the files are kept to a maximum size. All staff must ensure that after writing their daily entry, the file is put away neatly into the relevant filing cabinet, and that all loose pages have been secured in the relevant section within the file.</td>
<td>Weekly Checklist / Audit</td>
<td>Achievable</td>
<td>30/11/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>A Working group established to review the process in relation to the maintenance of records in the approved centre. Regular Analysis is completed to identify opportunities to improve the maintenance of</td>
<td>Local Compliance committee meeting minutes / analysis report</td>
<td>Achievable</td>
<td>30/11/2019</td>
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<tr>
<td>records processes. Analysis report attached.</td>
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### Code of Practice on the Use of Physical Restraint in Approved Centres

**Reason ID**: 10000431

Not all staff involved in physical restraint had signed that they read and understood the policy. 9.2(b)

<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>Policy dissemination session on physical restraint and code of practice conducted on August 2019. PPPG signature sheet reviewed and monitored on regular basis, Further policy dissemination session will be held within the approved centre, in November 2019, to ensure compliance with Code of Practice on physical restraints.</td>
<td>Review policy dissemination planner / PPPG signature sheet</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>HODs MDT</td>
<td></td>
</tr>
</tbody>
</table>

**Preventative Action**

Analysis is completed to identify opportunities for improvement.

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Analysis</th>
<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis is completed to identify opportunities for improvement.</td>
<td>Analysis</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>HODs</td>
</tr>
</tbody>
</table>

**Reason ID**: 10000432

In two episodes, it was not documented that the staff member responsible for leading in the physical restraint of a resident did not monitor the head and airway of the resident, 5.2. In one episode, it was not recorded in the clinical file that the consultant psychiatrist or duty consultant psychiatrist was notified, 5.3. The clinical practice form was not signed by the consultant psychiatrist within 24 hours, 5.7 (c). In three cases, it was not documented in the clinical file that the next of kin or representative was
notified, 5.9 (a). In one case inspected, physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode, 9.3. In two cases of physical restraint, it was not documented in the clinical file that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of the treatment, 5.8.

<table>
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<th>Achievable/Realistic</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Physical Restraints resource folder developed and implemented within the approved centre to ensure compliance with Code of Practice on physical restraints. Physical Restraints process algorithm developed and displayed within the approved unit. Physical restraints and post MDT review stickers introduced within the approved centre. Supporting Document attached.</td>
<td>Quarterly audit</td>
<td>Achieved</td>
<td>30/09/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Quarterly audit on use of Physical Restraints within the approved unit. Analysis is completed to identify</td>
<td>Quarterly audit / Analysis</td>
<td>Achievable</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>
opportunities to improve the processes for use of Physical Restraints. This is documented.
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.