Lakeview Unit, Naas General Hospital

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type: Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability
Other

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Mr Kevin Brady, Head of Service, Mental Health – CHO7

Inspection Team:
Martin McMenamin, Lead Inspector
Mary Connellan
Carol Brennan-Forsyth
Karen McCrohan
Marianne Griffiths

Inspection Date: 20 – 22 March 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 31 July – 3 August 2018

Date of Publication: Thursday 29 August 2019

2019 COMPLIANCE RATINGS

REGULATIONS: 7 Compliant, 1 Non-compliant, 1 Not applicable
RULES AND PART 4 OF THE MENTAL HEALTH: 2 Compliant, 2 Non-compliant
CODES OF PRACTICE: 4 Non-compliant
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
Contents

1.0 Inspector of Mental Health Services – Review of Findings ................................................................. 5
2.0 Quality Initiatives .................................................................................................................................. 10
3.0 Overview of the Approved Centre ......................................................................................................... 11
  3.1 Description of approved centre .......................................................................................................... 11
  3.2 Governance ......................................................................................................................................... 12
  3.3 Reporting on the National Clinical Guidelines ................................................................................... 13
4.0 Compliance ............................................................................................................................................... 14
  4.1 Non-compliant areas on this inspection ............................................................................................ 14
  4.2 Areas of compliance rated “excellent” on this inspection .................................................................... 14
  4.3 Areas that were not applicable on this inspection .............................................................................. 15
5.0 Service-user Experience ......................................................................................................................... 16
6.0 Feedback Meeting ................................................................................................................................... 18
7.0 Inspection Findings – Regulations ......................................................................................................... 19
8.0 Inspection Findings – Rules .................................................................................................................... 60
9.0 Inspection Findings – Mental Health Act 2001 .................................................................................... 64
10.0 Inspection Findings – Codes of Practice ............................................................................................ 65
Appendix 1: Corrective and Preventative Action Plan .................................................................................. 71
Appendix 2: Background to the inspection process ....................................................................................... 89
In brief

Lakeview Unit was located within Naas General Hospital and catered for all acute mental health admissions from the region from 18 years of age upwards and served the communities of County Kildare and West Wicklow, which had a population currently exceeding 241,538 (2016 Census). The bed capacity of the approved centre did not reflect the needs of the community population that the unit serviced. The approved centre had a service level agreement with the Department of Psychiatry, Portlaoise which was approximately 30 km away. This arrangement provided for the admission of up to ten residents who required higher levels of observation. Capital planning to replace the Lakeview Unit in Naas was underway.

The approved centre admitted residents through nine consultant-led community mental health teams in addition to the Psychiatry of Later Life (POLL) team which was led by two consultants and the Rehabilitation team led by one consultant.

The approved centre was comprised of two floors. The facilities upstairs could not be accessed after 20:00 as this area was locked at that time. This resulted in residents having access to just one small sitting room on the ground floor level for the duration of the evening.

Conditions to registration

**Condition 1:** To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Finding on this inspection:** The approved centre was not in breach of Condition 1 and the approved centre was compliant with Regulation 15: Individual Care Plan at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically and included audits undertaken by the Dangerous Goods Safety Advisers (DGSAs). There were proper facilities for the refrigeration, storage, preparation and serving of food. Catering areas and associated catering and food safety equipment were appropriately cleaned.
• Hazards and ligature points were minimised to the lowest practicable level, based on risk assessment. New window closures, sinks, showerheads, beds, and wardrobes had been installed to reduce ligature points, although the programme of replacement was not yet complete.
• The ordering, storage and administration of medication was satisfactory.
• Each resident had an individual risk assessment and risk management plan.

However:

• The medication discontinuation date was not documented in three cases and one prescription in the Medication Prescription and Administration Record was illegible.
• Not all staff had up-to-date mandatory training in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001 and Children First.

**Appropriate care and treatment of residents**

• Each resident had an individual care plan (ICP) which was developed by the multi-disciplinary team (MDT) and drawn up with the participation of the resident. Each resident was invited to complete a 'Weekly Self Review Form' and this was given to the MDT. The resident was invited to attend the MDT review. The reviewed ICPs had appropriate goals, treatment and care requirements and necessary resources for each resident. All ICPs were reviewed every week and updated by the resident’s MDT, and reflected the resident’s changing needs, condition, circumstances and goals.
• A list of all therapeutic services and programmes provided in the approved centre was available to residents and each resident was given a copy of the planned weekly schedule of activities. The therapeutic activities available included Pet Therapy, Yoga, Art Therapy, relaxation, Decider Skills, Mindfulness, Music Therapy and an occupational therapy group.
• Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care and there was good access to general health services in Naas General Hospital.

However:

• Where a resident had been secluded, the seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours and one resident was not informed of the ending of an episode of seclusion.
• There were a number of discrepancies in the use of physical restraint:
  o A designated staff member was not identified as being responsible for leading the physical restraint or for monitoring the head and airway of the resident.
  o The clinical practice form was not signed by a consultant psychiatrist within 24 hours.
  o The resident was not informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint and no reason was given for not informing the resident.
  o Where a resident had consented, the resident’s representative was not informed of the use of physical restraint, with no reason recorded in the clinical file.
Respect for residents’ privacy, dignity and autonomy

- Two appropriately qualified staff were in attendance at all times when searches were being conducted. Due regard was maintained in relation to upholding the resident’s dignity, privacy and gender during searches. The request for consent and the received consent were documented for every search of a resident and every property search.

- All bathrooms, showers and toilets had locks on the inside of the door. Where residents shared a room, the bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas.

- Measures were in place to ensure that the electronic notice board in the nurse’s office was not visible from the hall through the provision of a blind on the office window and the adoption of screen savers on the electronic notice board.

- Clear signs were evident in prominent positions, where CCTV cameras were located within the approved centre. All camera images were transmitted to the nursing station only and the camera system used to observe a resident was incapable of recording or storing a resident’s image.

- Considerable work had been completed on the upgrade of the toilets, sinks and furniture within the bedrooms and new furniture had been purchased for the sitting room.

However:

- The approved centre was not suitable for the care and treatment of people with a mental illness.
  - There were insufficient internal and external spaces for residents to move about.
  - There was only one sitting room downstairs as the upstairs area closed from 8pm, and it could not accommodate all residents at full capacity, as there was only 11 chairs available.
  - Overcrowding within the premises necessitated the use on occasions of the seclusion room as a bedroom. There was a small garden that was also a smoking area. A garden upstairs was only open when there were two staff available to supervise, and was limited to a number of hours only. Although there was some evidence of maintenance, this garden was in an untidy condition on inspection.
  - One of the newly upgraded shower rooms was not appropriately ventilated.
  - Appropriate signage and sensory aids were not provided. A door labelled 'telephone' was used for storage and a door labelled 'private' was a resident shower room.
  - The seclusion room was observed to be dark; the walls were coloured a dark green and staff reported that the blinds on the window could not be opened.
  - The maintenance manager confirmed that there was no preventive maintenance schedule in place at the time of inspection.

- The approved centre was not clean and hygienic.
  - Dust was evident on the top on the wardrobes and in ceiling panels, which also had numerous cobwebs, along the main corridor downstairs.
  - External windows were observed to be dirty.
  - The enclosed gardens upstairs and downstairs were littered with numerous cigarette butts.
  - The garden furniture and bin in the garden downstairs were observed to be dirty and dusty.
Residents’ dignity was compromised when the seclusion room was used as a bedroom on six occasions since the last inspection as the approved centre was over its registered capacity.

The approved centre did not have a dedicated Mental Health Tribunals room, although structural building works have been planned to develop one.

**Responsiveness to residents’ needs**

- A systematic review of menu plans had been undertaken by the catering manager to ensure that residents were provided with wholesome and nutritious food in line with their needs. This was undertaken three times a year with a multi-disciplinary group which included Speech and Language, Dietetics and staff from catering in the main hospital.

- There were planned activities scheduled during the week. Communal areas were suitable for recreational activities, and included a hair and beauty studio, an activity room, an art room, an outdoor garden area and a sitting room.

- A welcome information pack with booklets was available and information was clearly and simply written. It included housekeeping arrangements, including arrangements for personal property, visiting times, mealtimes, complaints procedures, and relevant advocacy and voluntary agencies.

- Residents were provided with written and verbal information on diagnosis. Information was also provided to residents on the likely adverse effects of treatments, including risks and other potential side-effects.

- All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. The nominated person maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes, and the complainant’s view of the outcome.

However:

- Interviews with residents suggested that there were not enough opportunities for indoor exercise. The approved centre previously had a treadmill, which was not in evidence on this inspection.

**Governance of the approved centre**

- There was clear evidence of well-structured governance arrangements and processes in place reflecting the Kildare West Wicklow Mental Health Services. The monthly minutes of the Kildare West Wicklow Mental Health Services management team meetings, Quality and Patient Safety and supporting committees, such as the audit committee, showed that the management team actively and comprehensively addressed issues such as bed capacity, MHC reports and action plans, the risk register, serious incidents, complaints, service development, and staff training and development.

- Performance was monitored through Key Performance Indicators (KPIs), by feedback from audits of ICPs and Corrective and Preventative Action Plans (CAPAs).

- Most members of the multi-disciplinary team had access to regular clinical supervision, with nursing having trained a number of staff to provide clinical supervision.
• Staff members also participated in Schwartz rounds which provided valuable opportunities for all staff to reflect on the emotional impact of their work through conversations facilitated by a local clinical lead and facilitator.

• Quality Improvement projects were assessed against the six drivers for improving quality. The approved centre have invested in developing the leadership skills of staff in order to have the appropriate people leading out on quality improvement projects and initiatives. Consultation includes both the resident cohort and staff through a number of forums to ensure all stakeholders are involved in the design and delivery of initiatives.

• The audit and monitoring systems extended beyond the approved centre in ensuring improvement in quality across services. MDT members attended compliance meetings, and contributed towards completion of CAPAs, policy meetings and auditing of ICPs, which was fed back through line management. The senior social worker also attended community meetings for service users in the approved centre to discuss any improvements to the service they were receiving as residents.

• Arrangements had been scheduled for the identification of a Project Team to advance the planning and design stage for a new 50-bed psychiatric unit.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A protocol was developed and implemented for presentations of individuals with complex treatment needs in ensuring the health and safety of all staff and residents. The protocol provided for the clear documented, up-to-date multi-disciplinary risk management plan for such presentations.

2. Completion of anti-ligature refurbishment of all bedrooms, blinds, as well as new furniture.

3. De-escalation area identified with new appropriate seating created to minimise episodes of aggression and the need for seclusion.


5. Medication Champion project initiated to provide ongoing support and updates for staff with queries or concerns in relation to medication management.

6. Additional Clinical Nurse Manager 3 posts filled to strengthen clinical care and governance.

7. Rehabilitation and Recovery Clinical Nurse Specialist (CNS) providing in-reach support to longer term residents awaiting appropriate placement.
3.0 Overview of the Approved Centre

3.1 Description of approved centre
Lakeview Unit was opened in 1988 and serviced the communities of County Kildare and West Wicklow, which had a population currently exceeding 241,538 (2016), an increase of 5% on the 2011 census numbers. The bed capacity of the approved centre did not reflect the needs of the community population that the unit serviced. This growth in population had placed an increased burden on the service. This has required the service to explore ways in which current services are to be provided in keeping with *Vision for Change* (50 acute in-patient beds per Mental Health Catchment Area). The approved centre had a service level agreement with another approved centre (Department of Psychiatry [DOP], Portlaoise) which was approximately 30 km away. This arrangement provided for the admission of up to ten residents who required higher levels of observation. On inspection, it was noted that there were five residents in DOP Portlaoise. Capital planning to replace the Lakeview Unit in Naas was underway. A project team was due to be formed in commencing the building requirements and design phase.

Lakeview Unit was located within Naas General Hospital and catered for all acute mental health admissions from the region from 18 years of age upwards. The approved centre admitted residents through nine consultant-led community mental health teams in addition to the Psychiatry of Later Life (POLL) team which was led by two consultants and the Rehabilitation team led by one consultant.

The approved centre was comprised of two floors. General access was through the main hospital entrance and the unit was well signposted within the hospital. There were external entrance doors on each floor which led to both the main hospital and to the exterior. The unit had two 6-bed dormitories, three 4-bed dormitories and five single rooms.

The upstairs area of the unit contained the therapy area, dining room, small sitting room, recreation room, offices and an ECT suite. The resident sleeping accommodation and nursing office were located downstairs. There was an internal paved garden area at ground level and a further garden was situated on the upstairs level. Visitor access to the approved centre was via an intercom system. The facilities upstairs could not be accessed after 20:00hrs as this area was locked at that time. This resulted in residents having access to just one small sitting room on the ground floor level for the duration of the evening.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>29</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>29</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>9</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>1</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>
3.2 Governance

There was clear evidence of well-structured governance arrangements and processes in place reflecting the Kildare West Wicklow Mental Health Services. Copies of the monthly minutes of the Kildare West Wicklow Mental Health Services management team meetings, Quality and Patient Safety and supporting committees such as the audit committee were provided to the inspection team. They showed that the management team actively and comprehensively addressed issues such as bed capacity, MHC reports and action plans, the risk register, serious incidents, complaints, service development and staff training and development.

There were very good linkages through a formalised service level agreement (SLA) with Naas General Hospital, in terms of clinical support for infection control, medication safety and access to medical consultancy. However, there was a need to clarify the exact provisions in relation to the formal arrangements in terms of accountability and monitoring processes for some services provided.

Performance was monitored through Key Performance Indicators (KPIs), by feedback from audits of ICPs and Corrective and Preventative Action Plans (CAPAs). These were circulated to all heads of discipline. Nursing management had an audit and monitoring schedule and led out on many of the audit processes.

Strategic goals were aimed at achieving stable staffing for the service to develop subspecialties which the service identified as being poorly resourced. A key aim of the service was to resolve the inpatient bed under provision, which had ‘worsened steadily in the last 15 years’. Other aims included maximising attendance by social workers and other members of the multi-disciplinary team at multi-disciplinary team meetings and care planning meetings in the approved centre.

To support this work the approved centre facilitated the following groups:

- Monthly Audits on a scheduled basis throughout the year. (MDT)
- Monthly Compliance committee meetings to review action plans from the audit process and approve new documentation and processes. (MDT)
- Monthly Senior Management team meetings (MDT)
- Quarterly CHO Quality and Patient Safety Committee meetings (MDT)
- Monthly Policy Committee meetings (MDT)
- Monthly Audit Committee meetings (MDT)
- Serious incident management team (Members of MDT)
- Monthly Quality and Patient Committee meetings (MDT)
- Monthly Nursing Metrics committee meetings. (Nursing)
- Weekly Senior Nurse Management meetings (Nursing)
- Monthly Nursing Metric Data Collection. (Nursing)

Most members of the multi-disciplinary team had access to regular clinical supervision, with nursing having trained a number of staff to provide Clinical Supervision.

For some professionals, fortnightly supervision was provided to staff grades and monthly supervision provided to senior staff grades. Other professionals operated on an informal basis through to regular
professional and clinical supervision every four-six weeks. Within occupational therapy, staff grades have access to peer support and an education group.

There was weekly contact between consultant staff. Whilst there was no formal supervision, there was some peer review elements built into the teaching schedule. Most CORU registered staff had regular review of learning objectives within individual staff personal development plans.

Staff members also participated in Schwartz rounds which provided valuable opportunities for all staff to reflect on the emotional impact of their work through conversations facilitated by a local clinical lead and facilitator.

Quality Improvement projects were assessed against the six drivers for improving quality. The approved centre have invested in developing the leadership skills of staff in order to have the appropriate people leading out on quality improvement projects and initiatives. Consultation includes both the resident cohort and staff through a number of forums to ensure all stakeholders are involved in the design and delivery of initiatives.

The audit and monitoring systems extended beyond the approved centre in ensuring improvement in quality across services, not just in a regulated setting. In many cases, projects and ideas were road tested for their effectiveness prior to rolling out. MDT members attended compliance meetings, contributed towards completion of CAPAs, policy meetings, auditing of ICPs which was fed back through line management. The senior social worker also attended community meetings for service users in the approved centre to discuss any improvements to the service they are receiving as residents.

It was noted that arrangements have been scheduled for the identification of a Project Team to advance the planning and design stage for a new 50 bed psychiatric unit.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X Low</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing and Administration of Medicines</td>
<td>X High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓ Moderate</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy (ECT)</td>
<td>✓</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X Critical</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X Low</td>
<td>X Low</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice Relating to the Admission of Children under the Mental Health Act 2001</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy (ECT)</td>
<td>X High</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and From an Approved Centre</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection
The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
<td></td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
<td></td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
<td></td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
<td></td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td></td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td></td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td></td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
<td></td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td></td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td></td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td></td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td></td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td></td>
</tr>
<tr>
<td>Regulation 29: Operation Policies and Procedures</td>
<td></td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td></td>
</tr>
</tbody>
</table>

### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
</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 met with seven residents. Residents were also provided with the opportunity to complete an anonymous experience questionnaire but only one resident chose to do so. Generally, residents were complimentary of food and activities as well as staff. Residents who met with the inspectors spoke positively about their experience with staff and the support they received within the unit. They spoke very positively regarding their experiences. The quality of meals available was positively regarded. They spoke positively regarding the expansion of both therapeutic activities and access to the upper level in the evenings. Some expressed some dissatisfaction with a perceived lack of activities in relation to ‘proper exercise facilities’. In addition, a resident referred to poor continuity of care in relation to information of medical appointments and no availability of a doctor to prescribe medication during the night.

The inspection team also spoke with the Irish Advocacy Network who subsequently submitted a Peer Advocacy Service Report in relation to Lakeview Unit. The report findings reflected the positive aspects of the service identified by the inspection team. They included very positive comments about how lovely the food was and the availability of tea/coffee trolley in the sitting room. They also felt that the upstairs area was a lovely place to relax, the quiet room especially, where it was nice to sit and look out at the lake. The group classes were good, and residents liked their time in the beauty room, getting their hair or nails done and also enjoyed going on the group walks around the lake. People were happy with the renovations that were undertaken of the toilets and bedrooms, and the new furniture in the unit was bright and cheerful.

Areas that residents identified as being in need of improvement included the stairs which were a problem for some residents, as they had to go outside of the unit to use the lift. There were often no chairs left out in the hallway at night time, so people who cannot sleep have nowhere to sit when the sitting room was
closed, apart from on their beds. One of the showers was not working for quite a while and sometimes the meal times were perceived as being rushed.

The upstairs area closed at 20:00 hrs which meant that there was only one seated area to watch TV downstairs; this meant that potentially only 11 seats were available for 29 people in the evening. Residents reported that they would like to have more talk therapy while in the unit and to be made aware of who their key nurse was, and also felt that counselling should be arranged for them when they are discharged from the unit. Residents also said that the seclusion room should not be situated beside the bedrooms as it affects some residents sleep when a person was distressed it can also leave some of the other residents feeling very anxious.
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:

- Head of Service (Registered Proprietor)
- Consultant Psychiatrist representing the Clinical Director
- Assistant Director of Nursing representing the Director of Nursing
- Consultant Psychiatrist
- Principal Psychologist
- Senior Social Worker
- Occupational Therapy Manager
- Assistant Director of Nursing (ADON) x 3
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2 x 2
- Clinical Nurse Manager 1
- Pharmacist
- Maintenance Manager
- Clerical Staff X 2
- Operations Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.
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 August 2016. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 approved centre used red alert stickers for residents with the same or similar names. Residents were required to wear wristbands as a method of identification. An alert sticker which included the residents name, address and date of birth were used in clinical files and Medication Prescriptions and Administration Records (MPARs). An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

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

**Quality Rating**

<table>
<thead>
<tr>
<th>COMPLIANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
</tr>
</tbody>
</table>

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

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. 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 by the catering manager to ensure that residents were provided with wholesome and nutritious food in line with their needs. This was undertaken three times a year with a multi-disciplinary group which included Speech and Language, Dietetics and staff from catering in the main hospital. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition. The catering department were highly commended for food by a recent National HSE Audit.

**Evidence of Implementation:** Residents had at least two choices for meals and could, within reason also order alternative foods not on the menu. Nutritional and dietary needs were assessed where necessary, using an evidence-based nutrition assessment tool, and this was reflected in residents’ individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a specifically contracted dietitian. Weight charts were implemented, monitored, and acted upon for residents, where appropriate.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in September 2016. The policy included all of the requirements of the Judgement Support Framework including food preparation, handling, storage, distribution and disposal controls.

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 and included audits undertaken by the Dangerous Goods Safety Advisers (DGSAs). Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation and serving of food. Catering areas and associated catering and food safety equipment were appropriately cleaned. Appropriate protective equipment (including Personal Protective Equipment (PPE), where required) was available and used during the food serving process. The modern styling of the dining room was conducive to a relaxed dining experience.

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 August 2018. The policy included all include any 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. No resident was wearing nightclothes at the time of inspection, as residents change out of nightclothes during daytime hours unless specified otherwise in their ICPs.

Evidence of Implementation: Residents had an adequate supply of individualised clothing. Emergency personal clothing was available to residents, where required that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices.

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

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

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

Evidence of Implementation: Each resident had a lockable wardrobe. Residents were advised to send any unwanted property home, if possible. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The approved centre had secure storage for residents’ property and monies, with larger sums of money sent to the general office. 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.

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

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

Monitoring: A record was maintained of the residents’ attendance at recreational activities within the resident's clinical files. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: There were planned activities scheduled during the week and residents had access to board games, music, pool table, puzzles etc., on week days and on weekends. Interviews with residents suggested that there were not enough opportunities for indoor exercise. The approved centre previously had a treadmill, which was not in evidence on this inspection. Communal areas were suitable for recreational activities, and included a hair and beauty studio, an activity room, an art room, an outdoor garden area and a sitting room. The therapy department developed a weekly activities timetable. Timetable copies were given to the residents and this information was also displayed on the noticeboards in the approved centre.

Resident decisions on whether or not to participate in activities were respected and documented, as appropriate. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. Feedback was sought from the residents at their weekly community meetings. On a quarterly basis, residents were also given a feedback survey to complete. This feedback was considered when developing the activities timetables.

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

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

**INSPECTION FINDINGS**

**Processes**: The approved centre had a written policy entitled ‘Cultural Diversity’ in relation to the facilitation of religious practice by residents, which was last reviewed in November 2017. The policy addressed requirements of the *Judgement Support Framework*, except that it did not outline a process for respecting religious beliefs during the provision of services, care, and treatment.

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

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

**Evidence of Implementation**: There were facilities provided within the approved centre for residents’ religious practices, insofar as was practicable. Care and services provided within the approved centre were respectful of the residents’ religious beliefs and values. This was especially evident in terms of diet, accommodating prayer and access to religious services. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in April 2018. The policy included all include any 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 where applicable 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 appropriate and reasonable were publicly displayed at the entrance to the approved centre. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Appropriate arrangements and facilities were in place for children visiting a resident. Children visiting were accompanied at all times to ensure their safety. At the time of inspection, there were no residents who had restrictions on their rights to receive visitors.

The approved centre was compliant with this regulation. The quality assessment was rated excellent as 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 August 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 postal mail and telephone (there was no Wi-Fi), unless otherwise risk-assessed with due regard to the residents’ well-being, safety, and health.

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 October 2016. 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: Searches were only conducted for the purpose of creating and maintaining a safe environment for residents and staff. The resident search policy and procedure was communicated to all residents. Two appropriately qualified staff were in attendance at all times when searches were being conducted. Due regard was maintained in relation to upholding the resident's dignity, privacy and gender during searches. The request for consent and the received consent were documented for every search of a resident and every property search. Environmental searches occurred from time to time and were documented in the same way as personal searches. A separate search form was completed and the search was also documented in the clinical notes.
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 July 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in November 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The ICP was a composite set of documents with an identified section in the clinical file, and with review documentation added each week to this section. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Each resident was invited to complete a ‘Weekly Self Review Form’ and this was given to the MDT. The resident was invited to attend the MDT review. The ICP included an individual risk management plan.

Ten individual care plans were inspected. Two residents were not offered a copy of their care plan but a reason for this was documented. A daily key worker was identified (who was always a member of the nursing staff), in attempting to ensure continuity in the implementation of a resident’s ICP as much as possible.

The reviewed ICPs had appropriate goals, treatment and care requirements and necessary resources for each resident. All ICPs were reviewed every week and updated by the resident’s MDT and reflected the resident’s changing needs, condition, circumstances and goals.

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

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

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

Evidence of Implementation: A list of all therapeutic services and programmes provided in the approved centre was available to residents, through a weekly updated bulletin board, in the main activities area and also beside the dining facility. Each resident was given a copy of the planned weekly schedule of activities and copies were evident throughout the approved centre. These clearly set out what was available each day and for the week ahead. The therapeutic activities available included Pet Therapy, Yoga offered weekly by a qualified Yoga teacher, Art Therapy provided weekly by a qualified art psychotherapist, relaxation in group format and one to one as required, Decider Skills as required, Mindfulness provided weekly by a trained mindfulness facilitator, Music Therapy provided weekly by a qualified music therapist, and an occupational therapy group provided in three sessions weekly and on a one to one basis on referral or as required. Each catchment area team had psychology, social work and occupational therapy on a one to one basis according to the assessed needs of the individual resident.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Services were provided as required by Naas General Hospital for speech and language, physical occupational therapy, dietitian services, physiotherapy and any other services provided by the hospital. Staff from relevant departments attended the approved centre to see the resident’s that were referred to them, based on an assessed need.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. The approved centre had two full time nursing activity staff, one full time occupational therapist and other allied health professionals as required, from each respective catchment area team. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes, through the insertion of a completed adhesive label in each resident’s clinical file.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 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.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in April 2018. The policy included all of the requirements of the Judgement Support Framework.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> 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.</td>
</tr>
<tr>
<td><strong>Monitoring:</strong> 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.</td>
</tr>
<tr>
<td><strong>Evidence of Implementation:</strong> The clinical file of one resident was reviewed. Communication records with the receiving facility were documented and available on inspection, including agreement of resident receipt prior to the transfer. Full and complete written information was sent in advance and also accompanied the resident upon transfer. The reason for the transfer was recorded, as was the resident’s care and treatment plan, including their needs, risk level and current medications.</td>
</tr>
<tr>
<td>A copy of the transfer form relevant to the resident transfer was not evident within the clinical file, as it had been retained within the transfer book.</td>
</tr>
<tr>
<td>The approved centre was compliant with this regulation. The quality assessment was rated was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.</td>
</tr>
</tbody>
</table>
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in October 2016. The medical emergencies policy was last reviewed in July 2017. The policies and procedures included all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored within the new updated six monthly assessment form, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. This was managed by the mental health act administrator who informed the medical team in advance of upcoming requirements for six monthly physical examination and investigations. Analysis had been completed to identify opportunities for improving general health processes through the appointment of a general health monitoring nurse and the introduction of a new six monthly health assessment form.

Evidence of Implementation: Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care.

Residents received appropriate general health care interventions in line with individual care plans, with good access to general health services in Naas General Hospital. Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, at least every six months. Clinical records documented residents who had refused general health assessments. Clear arrangements were in place with Naas General Hospital for residents to access general health services and for their referral to other health services as required.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 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 July 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: A welcome information pack with booklets was available in the required formats to support resident needs, and information was clearly and simply written. It included housekeeping arrangements, including arrangements for personal property, visiting times, mealtimes, complaints procedures, and relevant advocacy and voluntary agencies.

Residents were provided with the details of their multi-disciplinary team verbally and through the provision of an individual care plan information booklet. Residents were provided with written and verbal information on diagnosis, unless it posed a risk to the resident’s health or well-being. Information was also provided to residents on the likely adverse effects of treatments, including risks and other potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to resident need. The pharmacist provided information when required. The approved centre used www.medicines.ie to source information. The information in the documents 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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 21: Privacy

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed 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 manner in which staff addressed and communicated with residents was respectful and discretion was used when discussing medical conditions or treatment. Staff sought the resident’s permission before entering their room. All residents were wearing clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls.

All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to a resident; however, single bedrooms could not be locked from the inside without a key. Where residents shared a room, the bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Measures were in place to ensure that the electronic notice board in the nurse’s office was not visible from the hall through the provision of a blind on the office window and the adoption of screen savers on the electronic notice board.

Residents’ dignity was compromised when the seclusion room was used as a bedroom on six occasions since the last inspection as the approved centre was over its registered capacity.

The approved centre was non-compliant with this regulation because residents’ dignity was compromised when the seclusion room was used as a bedroom.
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.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in August 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The approved centre’s premises maintenance programme.
- The approved centre’s cleaning programme.
- The approved centre’s utility controls and requirements.

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 a completed hygiene audit undertaken by the cleaning contractor in January 2019. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises in terms of the need for a dedicated tribunal room and the overall requirement for new bespoke premises.

Evidence of Implementation: The approved centre was not suitable for the care and treatment of people with a mental illness. There were insufficient internal and external spaces for residents to move about. The approved centre did not provide appropriately sized communal rooms. There was only one sitting room downstairs as the upstairs area closed from 8pm, and it could not accommodate all residents at full capacity, as there was only 11 chairs available. The lack of seating in the sitting room meant the furnishings did not support resident independence and comfort. Overcrowding within the premises necessitated the use on occasions of the seclusion room as a bedroom. There was a small garden that was also a smoking area. A garden upstairs was only open when there were two staff available to supervise, and was limited

NON-COMPLIANT
Quality Rating Requires Improvement
Risk Rating HIGH
to a number of hours only. Although there was some evidence of maintenance, this garden was in an untidy condition on inspection.

One of the newly upgraded shower rooms was not appropriately ventilated. This shower room was also out of order at the time of the inspection. Staff reported that it had been out of order for approximately one week. Appropriate signage and sensory aids were not provided to support resident orientation needs. A door labelled 'telephone' was used for storage and a door labelled 'private' was a resident shower room.

The seclusion room was observed to be dark; the walls were coloured a dark green and staff reported that the blinds on the window could not be opened. The lighting elsewhere in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. Heating could only be safely controlled by either turning on or turning off, all of the radiators in the unit.

Hazards and ligature points were minimised to the lowest practicable level, based on risk assessment. New window closures, sinks, showerheads, beds, and wardrobes had been installed to reduce ligature points, although the programme of replacement was not yet complete. The maintenance manager confirmed that there was no preventive maintenance schedule in place at the time of inspection; however, the approved centre was in the process of developing such a schedule. Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to its implementation for possible impact on current residents and staff. Considerable work had been completed on the upgrade of the toilets, sinks and furniture within the bedrooms and new furniture had been purchased for the sitting room. The approved centre did not have a dedicated Mental Health Tribunals room, although structural building works have been planned to develop one.

The approved centre was not clean and hygienic. Dust was evident on the top on the wardrobes and in ceiling panels which also had numerous cobwebs, along the main corridor downstairs. External windows were observed to be dirty. The enclosed gardens upstairs and downstairs were littered with numerous cigarette butts, and the garden furniture and bin in the garden downstairs, were observed to be dirty and dusty.

The deficiencies identified on inspection were remedied through additional cleaning resources and maintenance support during the inspection, with assurances that a solution would be found for the proper functioning of window blinds in the seclusion room. Maintenance evidenced that they were in the process of obtaining various costings, e.g., weeding gardens, power hosing of garden, fixing garden furniture, deep cleaning of light fittings, new linoleum in the dining room and unit painting.

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

a) The premises were not adequately clean 22 (1)(a).
b) The premises were not adequately ventilated, 22 (1)(b).
c) The approved centre did not provide adequate and suitable furnishings with due regard to the number of residents in the approved centre, 22 (2).
d) The condition of the physical structure and the overall approved centre environment was not developed with due regard to the needs and well-being of residents, because it did not have a dedicated Mental Health Tribunals room and there was inadequate seating areas in the lower part of the unit, 22 (3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

Training and Education: Whilst medical staff as well as pharmacy staff, had signed the signature log to indicate that they had read and understood the policy, not all nursing staff had done so. 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. This training was documented.

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

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. A clear record, however, of the date of discontinuation for each medication was not maintained in three cases. In addition, all entries in the MPARs were not legible; there was one illegible entry in one MPAR, and this was rectified immediately during the inspection.

The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident’s MPAR. The signature of the medical practitioner was present on each MPAR entry.

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

At the time of the inspection, there were no residents on Schedule 2 drugs. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Refrigerators used for medication storage were not compliant with the requirements outlined in the guidelines.
were used only for this purpose; however, a log of the temperature of the refrigeration storage unit was only recorded on a weekly basis and was not logged on a daily basis. No current resident was prescribed crushed medication. An inventory of medications was conducted on a weekly basis, checking the name and dose of medication, quantity of medication, and expiry date.

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

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

a) The medication discontinuation date was not documented in three cases, 23 (1).

b) One entry in the MPAR was illegible, 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 series of written policies in relation to the health and safety of residents, staff, and visitors, which was last reviewed in April 2018. It had an associated safety statement, dated January 2019. It had written operational policies and procedures in relation to infection prevention control guidelines (September 2015), decontamination of the environment (November 2016), and many more individual policies. The policies combined constituted a comprehensive suite of policies including referenced Naas General Hospital based policies, procedures, protocols and guidelines. The policies and the safety statement included all of the requirements of the *Judgement Support Framework*.

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

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

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

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

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>Quality Rating</th>
<th>Excellent</th>
</tr>
</thead>
</table>

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in September 2016. The policy addressed all requirements of the Judgement Support Framework, including the purpose and function of using CCTV for observing residents in the approved centre.

Training and Education: 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 relating to the use of CCTV, as set out in the policy.

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

Evidence of Implementation: The approved centre had external cameras at the entrances to the unit. There were also two internal cameras, one in the upstairs garden and one in the seclusion room. Clear signs were evident in prominent positions, where CCTV cameras or other monitoring systems were located within the approved centre. All camera images were transmitted to the nursing station only and the camera system used to observe a resident was incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

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 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. The policy was last reviewed in April 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.

The policies and procedures did not address the evaluation of training programmes.

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 based on identified needs and reviewed yearly. This was documented. The numbers and skill mix of staff had reviewed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. The numbers and skill mix of staffing were sufficient to meet resident needs. Staff were recruited and vetted in accordance with the HSE’s policy and procedure for recruitment, selection and appointment. Staff had the appropriate qualifications to do their job. The required number of staff were on duty at night to ensure safety of residents in the event of a fire or other emergency. A planned and actual staff rota was maintained and an appropriately qualified staff member was on duty and in charge at all times; this was documented. There was an organisational chart which identified the leadership, management structure,
and lines of authority and accountability. Where agency staff were used, there was a comprehensive contract between the approved centre and registered/licensed staffing agency which set out the vetting requirements for potential staff.

There was an annual staff training plan completed to identify the required training and skills development in line with the assessed needs of the resident group profile. New staff received orientation and an induction. Staff received training in:

- Manual handling.
- Infection control and prevention.
- Dementia care.
- Risk management.
- Recovery-centred approaches to mental health care and treatment.
- Incident reporting.
- Protection of children and vulnerable adults.

However, not all staff had up to date mandatory training in:

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

<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</td>
<td>30</td>
<td>68%</td>
<td>36</td>
<td>82%</td>
<td>37</td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td>13</td>
<td>93%</td>
<td>9</td>
<td>64%</td>
<td>12</td>
</tr>
<tr>
<td>Medical/NCHD</td>
<td>14</td>
<td>82%</td>
<td>13</td>
<td>76%</td>
<td>10</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>7</td>
<td>80%</td>
<td>7</td>
<td>80%</td>
<td>8</td>
</tr>
<tr>
<td>Social Worker</td>
<td>*</td>
<td>70%</td>
<td>*</td>
<td>100%</td>
<td>*</td>
</tr>
<tr>
<td>Psychologist</td>
<td>*</td>
<td>71%</td>
<td>*</td>
<td>71%</td>
<td>*</td>
</tr>
</tbody>
</table>

*No data available

Opportunities were made available and communicated to staff, and staff were supported to undertake further education. In-service training was completed by appropriately trained and competent individuals. A hand hygiene trainer / co-ordinator had been allocated. There were facilities and equipment available for staff in-service education and training. Staff training was documented and staff training logs were maintained. Recovery-centred approaches to mental health care and treatment training were rolled out as part of a service-wide initiative.
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>Lakeview Unit</td>
<td>CNM3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN)

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, Professional Management of Aggression and Violence and Children First 26(4).

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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in July 2018. 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: All clinical 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 policies. All clinical staff had been trained in best-practice record keeping.

Monitoring: Resident records were audited using monthly nursing metrics 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: The approved centre maintained a record for every resident who was assessed or provided with care. Only authorised staff could access data and make new entries, and residents’ could access records in line with data protection legislation. Staff had access to the information needed to carry out their job.

In one clinical file observed, there was a sequence of pages where no identifier or date had been recorded. In some instances, the resident’s name only was written, and in one clinical file observed, not all continuation sheets had an identifier or a date. Resident records were not maintained using an identifier that was unique to the resident or some other effective method on all clinical records. In some instances, the name of the resident was the only identifier recorded on the page. On other documentation, neither the residents name nor small adhesive addressograph label was placed on each clinical documentation.
sheet. In some instances, not all continuation sheets had an identifier or a date. The 24-hour clock was not consistently used for each time entry within the clinical files.

Where an error was made, this was not scored out with a single line and the correction written alongside with date, time and initials.

Documentation of food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements.

The approved centre was non-compliant with this regulation because not all records were maintained in a manner so as to ensure completeness and accuracy, 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 not up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record:

- Diagnosis on admission or the provisional diagnosis as the reason for admission was not always recorded and ICD and diagnostic language was not always used.
- The register of residents was not kept up to date. The legal status of the patient/resident was not changed on the register.
- The discharge date or discharge diagnosis was not always recorded.

No amendments had been made to the register following last year’s inspection report.

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

a) The register was not up to date, as it did not reflect the current legal status of all the residents, 28(1).
b) Diagnosis on admission or the provisional diagnosis as the reason for admission was not always recorded and ICD and diagnostic language was not always used, 28(2).
c) The admission and discharge diagnosis had not been properly recorded for all the residents, 28(2).
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 November 2018. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies. The review schedule had been allocated within yearly quarters. Analysis and improvement had been undertaken in relation to update of physical health policy in-line with feedback from last inspection.

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately formatted, approved, and communicated to all relevant staff. A lot of work had been invested in Policies, Protocols, Procedures and Guidelines most of which had been reformatted and developed in the last year, which reflected the new HSE template and the quality criterion within the Judgement Support Framework.

Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff. Generic policies were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre had a written statement to this effect.

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.
(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, which was last reviewed in April 2016. The policy and procedures 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 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 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. However, the approved centre did not provide a suitable facility to support the tribunal process. Mental Health Tribunals were held in the art room, which was not suitable and did not afford full privacy. Plans were at an advanced stage to re-construct a suitable tribunal room from within existing office space.

The approved centre was non-compliant with this regulation because the approved centre did not provide a suitable facility to support the tribunal process and therefore did not fully co-operate fully with Mental Health Tribunals, 30 (1).
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints, which were last reviewed in April 2018. The policy and procedures included all of the requirements of the Judgement Support Framework.

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 as complaints were a standing agenda item on the CHO Quality and Patient Safety meeting. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: The approved centre followed the HSE policy approach of ‘Your service, Your say’. Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. Residents and their representatives were assisted to make complaints using appropriate methods and provided with contact details for an advocate. Advocate information details were available on noticeboards and in the resident welcome information pack. There was a clearly identified nominated person responsible for dealing with complaints. There were methods for addressing minor complaints, including at weekly community meetings. Minor complaints were recorded in a log. The nominated person dealt with minor complaints that could not be addressed locally.

All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and
informed promptly of the outcome and details of the appeals process. The nominated person maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes, and the complainant’s view of the outcome. This was kept distinct from the resident’s individual care plan.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected because of the complaint being made. All information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

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 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 2018.

Other supporting policies included:

- Safety Statement (January 2019).
- Management of Ligatures in the Approved Centre (2016)

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

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that
they had read and understood the policies. All staff interviewed were able to articulate the risk management processes, as set out in the policies. 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 approved centre maintained a risk register. Health and safety risks were documented within the risk register, as appropriate. Clinical risks were also documented and included non-compliances with the regulations and the regulatory enforcement condition attached to registration. The approved centre had access to a designated safety and risk advisor, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes. The risk management procedures at corporate level actively reduced identified risks to the lowest practicable level of risk. The Risk register was actively managed with analysis of risk category, status, rating and actions recorded within the risk register.

Individual resident risk assessments were completed prior to and during resident transfer, discharge, physical restraint, and in conjunction with medication requirements or administration. Multi-disciplinary teams, residents, and their representatives were involved in the development, implementation, and review of individual risk management processes. The approved centre had representation on the Area Management Quality and Safety committee which met monthly and had access to a quality and risk advisor.

Incidents were recorded and risk-rated in a standardised format. Risks rated as greater than ten were escalated to the Quality and Safety committee for further review. Where appropriate, a Preliminary Assessment Form (PAF) was completed and escalated. The designated safety and risk advisor reviewed incidents for any trends or patterns occurring in the services, and clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of that review and recommended actions. The Mental Health Commission was provided with a six-monthly summary report of all incidents, with information anonymised at a resident level.

There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures. Fire drills have been undertaken, timed and recorded. Whilst the need for personal emergency evacuation procedures for residents had been identified, none had been undertaken at the time of inspection. The requirements for the protection of children and vulnerable adults were appropriate and implemented.

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

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 20 July 2018. It contained protocols that were developed in line with best international practice, including:

- The storage of Dantrolene.
- The management of cardiac arrest.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite which included appropriate waiting and recovery facilities. ECT machines were regularly serviced and this was documented. There was a named consultant psychiatrist with overall responsibility for ECT and a named consultant anaesthetist.

The clinical record of one involuntary patient receiving ECT was reviewed. The patient had been assessed as not having capacity to provide consent and a Form 16 was documented. There was no documentary evidence available of whether the patient was informed of their right to access an advocate of their choosing at any stage. Each session of ECT was documented in the clinical file together with details of the dose and duration of seizure attained.

The approved centre was non-compliant with this rule because the patient was not informed of their right to access an advocate 2.6.
Section 69: The Use of Seclusion

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in October 2018. The policy addressed the following:

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

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

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

Evidence of Implementation: Three episodes of seclusion were reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents’ best interests, when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident’s unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner or registered nurse. A consultant psychiatrist was notified as soon as practicable of the use of seclusion. Seclusion orders did not last longer than eight hours. The resident was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless detrimental to resident. One resident was not informed of the ending of an episode of seclusion. Cultural awareness and gender sensitivity was demonstrated. Residents’ clothing respected their right to dignity, bodily integrity, and privacy.

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of resident well-being was made by a nurse every 15 minutes, including level of distress and behaviour. Following risk assessment, a nursing review took place every two hours. During this review, at least two staff entered the seclusion room.

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) “A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section “patient” includes –
   (a) a child in respect of whom an order under section 25 is in force, and
   (b) a voluntary patient.

NON-COMPLIANT
Risk Rating: HIGH
medical review of the patient was undertaken no later than four hours after the commencement of the episode of seclusion, and then reviewed every four hours.

The seclusion initiation was recorded in a clinical file and seclusion register by the person who initiated seclusion. The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. The resident’s representative was informed, and this was recorded in each clinical file. A copy of the seclusion register was placed in each clinical file. Each episode reviewed by members of the multi-disciplinary team and documented in clinical file within two working days.

Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. Residents in seclusion had access to adequate toilet and washing facilities. All furniture and fittings were of a design and quality so as not to endanger patient safety. However, the seclusion room was used as a bedroom when the approved centre was in excess of its registered bed capacity.

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

a) The seclusion room was used as a bedroom, 8.4.

b) The seclusion register not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours, 3.5.

c) One resident was not informed of the ending of an episode of seclusion, 7.3.
Part 4 of the Mental Health Act 2001 was not applicable to this approved centre at the time of the inspection. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
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, which was last reviewed in October 2018. It addressed all of the requirements specified in this Code of Practice.

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

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

Evidence of Implementation: Three episodes of physical restraint were reviewed on inspection. Physical restraint was used in rare, exceptional circumstances, and in the resident’s best interests, where the resident posed an immediate threat of serious harm to self or others. Physical restraint was only used after all alternative interventions to manage resident’s unsafe behaviour had been considered and after a risk assessment.

Cultural awareness and gender sensitivity were demonstrated. Special consideration was given when restraining a resident who was known to have experienced physical or sexual abuse. Where practicable, a same sex staff member present at all times during the episode. Staff were aware of relevant considerations in individual care plan pertaining to resident’s requirements and needs in relation to the use of physical restraint.

Physical restraint was initiated by an appropriate health practitioner in accordance with the policy on physical restraint. In one episode, a designated staff member was not identified as being responsible for leading the physical restraint or for monitoring the head and airway of the resident. A consultant psychiatrist or duty consultant psychiatrist was notified as soon as was practicable; this was recorded in clinical file. Orders for physical restraint lasted for no longer than 30 minutes.

A registered medical practitioner completed a medical examination of the resident no later than three hours after the start of an episode of physical restraint. One resident was not informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint and no reason was given for not informing the resident. Where a resident had consented, the resident’s representative was not informed of the use of physical restraint, with no reason recorded in the clinical file. In one case, the resident did not consent to this communication and this was documented and respected.

Residents were afforded the opportunity to discuss the episode with members of the multi-disciplinary team as soon as practicable. Each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in clinical file within two working days of the episode. The episode was recorded in clinical file. A clinical practice form was completed by an appropriate person within three hours of the episode. In one episode, the form was not signed by a consultant psychiatrist within 24 hours.

The approved centre was non-compliant with this code of practice for the following reasons:
a) In one episode of physical restraint, a designated staff member was not identified as being responsible for leading the physical restraint or for monitoring the head and airway of the resident, 5.2.
b) In one episode of physical restraint, the clinical practice form was not signed by a consultant psychiatrist within 24 hours.
c) In one episode of physical restraint, the resident was not informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint and no reason was given for not informing the resident, 5.8.
d) Where a resident had consented, the resident’s representative was not informed of the use of physical restraint, with no reason recorded in the clinical file, 5.9(a).
Admission of Children

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in March 2019. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

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

Evidence of Implementation: Age-appropriate facilities and a programme of activities were not provided by the approved centre. Provisions were in place to ensure the safety of the child through one-to-one nursing, to respond to the child’s special needs as a young person in an adult setting, to ensure the right of the child to have his/her views heard, and for the continuation of the child’s education as appropriate.

The child had their rights explained and information about the ward and facilities provided in an understandable way. However, there was no record of the child’s understanding of this. The approved centre did not have specific access to child advocacy services; however, the advocate for adult services was available.

Appropriate visiting arrangements for families were available, with visiting facilitated within the child’s bedroom area or a private space upstairs. Appropriate accommodation was designated, with the child placed in a single en suite bedroom. Observation arrangements, including the assignment of a designated staff member, was provided as considered clinically appropriate. Staff observation respected gender sensitivity.

Advice from the Child and Adolescent Mental Health Service was available. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. The Commission was notified of the child being admitted to an approved centres for adults within 72 hours of admission using the associated notification form. Staff having contact with the child had undergone Garda vetting.

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

a) Age-appropriate facilities and a programme of activities were not provided, 2.5 (b).

b) Children did not have access to age-appropriate advocacy facilities, 2.5 (g).

c) The clinical file did not record the child’s understanding of the explanation of their rights and information about the ward and facilities, 2.5 (h).
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 20 July 2018. It contained protocols that were developed in line with best international practice, including:

- The procedure for the storage of Dantrolene.
- Management of cardiac arrest.
- Management of anaphylaxis.

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 which included appropriate waiting and recovery facilities. ECT machines were regularly serviced and this was documented. There was a named consultant psychiatrist with overall responsibility for ECT; however, there was no named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses, one of whom was a designated ECT nurse were present at all times in the ECT suite when ECT was being administered.

The file of one voluntary patient who had received ECT was reviewed. The patient had received appropriate information, both verbal and written, explaining the nature, purpose, and side-effects of the treatment proposed. There was however, no evidence to demonstrate that the resident had been informed of their right to access an advocate of their choosing. An assessment of capacity to consent was undertaken and documented. Evidence of systematic monitoring on cognitive functioning throughout the programme of ECT was also documented.

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

a) There was no named consultant anaesthetist with overall responsibility for anaesthesia, 11.2.
b) A resident was not informed of their right to access an advocate, 4.6.
INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission, transfer, and discharge policies included all of the policy-related criteria for this code of practice, and were last reviewed in May 2018, April 2018, and November 2016 respectively.

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

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

Evidence of Implementation:

Admission: Admissions were on the basis of mental illness or mental disorder. Admission assessment was completed, which included the presenting problem, current and historic medication, risk assessment, and physical examination, amongst other topics. With resident consent, their representative was involved in the admission process. A key worker system in place.

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

Discharge: A discharge plan was completed, and included estimated date of discharge, documented communication with the relevant health practitioners, and a follow-up plan. It did not include reference to early warning signs of relapse and risks. A discharge meeting was held and attended by resident, key worker, relevant members of multi-disciplinary team, and a resident family member or representative where appropriate.

A discharge assessment addressed psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan and informational needs. The discharge was coordinated by a key worker. A preliminary discharge summary was sent to the appropriate health practitioner within three days, and a comprehensive discharge summary was issued within 14 days. Discharge summaries included details of diagnosis, medication, follow-up arrangements, amongst other details; it did not reference mental state at discharge or risk issues such as signs of relapse. The resident’s representative was involved in the discharge process, where appropriate. A timely follow-up appointment was made.

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

a) Discharge plans did not include references to early warning signs of relapse and risk, 34.2.

b) Discharge summaries did not include details of mental state at discharge or risk issues such as signs of relapse, 38.4.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>The premises were not adequately clean, 22 (1)(a).</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>1000258</td>
<td>Corrective Action</td>
<td>Cleaning schedule has been revised and updated. Funding approved to carry out additional cleaning</td>
<td>Monthly Hygiene Audit</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Operations Manager Director of Nursing</td>
</tr>
<tr>
<td></td>
<td>Preventative Action</td>
<td>Cleaning Schedule revised and hygiene audit carried out monthly</td>
<td>Monthly Audit Policy Review</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Senior Management Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>The premises were not adequately ventilated, 22 (1)(b).</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>1000259</td>
<td>Corrective Action</td>
<td>A new contract issued for cleaning and maintenance of the current ventilation system.</td>
<td>Captured on the monthly hygiene audit</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Operations Manager Director of Nursing</td>
</tr>
<tr>
<td></td>
<td>Preventative Action</td>
<td>Approved Centre Complaints Log and Maintenance Log reviewed by ADON for the approved centre will be monitored to avoid any recurrence of the issue.</td>
<td>Monthly Hygiene Audit</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Operations Manager Director of Nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>The approved centre did not provide adequate and suitable furnishings with due regard to the number of residents in the approved centre, 22 (2).</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>1000260</td>
<td>Corrective Action</td>
<td>Funding is approved for a standalone new build and a project team is in place to progress this. This will provide adequate seating areas in the longer term. The HSE Estate are being tasked with a review of seating arrangement in Lakeview Unit</td>
<td>Project Team is appointed and operational</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Senior Management Team and HSE Estate Management Director of Nursing</td>
</tr>
<tr>
<td></td>
<td>Preventative Action</td>
<td>Funding is approved for a standalone new build and a project team is in progress reports</td>
<td>Project Team progress reports</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Senior Management Team</td>
</tr>
</tbody>
</table>
place to progress this. This will provide adequate seating areas in the longer term. The HSE Estate are being tasked with a review of seating arrangement in Lakeview Unit

<table>
<thead>
<tr>
<th>Reason ID : 10000261</th>
</tr>
</thead>
</table>

The condition of the physical structure and the overall approved centre environment was not developed with due regard to the needs and well-being of residents, because it did not have a dedicated Mental Health Tribunals room and there was inadequate seating areas in the lower part of the unit and 22 (3).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>A tender has been approved for the development of a dedicated tribunal room. Work is scheduled to commence Autumn 2019. This project will deliver a dedicated tribunal room and adjoining interview room for the legal rep in a self-contained space in the approved centre. Access to the upper recreational area in the approved centre has been extended until 8pm (7 days). This in turn allows access to more suitable and adequate furnishings. Extra furnishings and seating areas have been provided affording the patients more appropriate relaxation space in the approved centre. A standalone new build has been passed and a project team will be in place early 2019 to progress this. This will provide adequate seating areas in the longer term.</td>
<td>A tender has been approved for the development of a dedicated tribunal room.</td>
<td>Achievable</td>
<td>04/01/2022</td>
</tr>
</tbody>
</table>

and HSE Estate Management Director of Nursing
<table>
<thead>
<tr>
<th>Preventative Action</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>We are currently hosting the tribunals in the most appropriate space available in the unit. Interview space is also provided. Access to the upper recreational area in the approved centre has been extended until 8pm (7 days). This in turn allows access to more suitable and adequate furnishings. Extra furnishings and seating areas have been provided affording the patients more appropriate relaxation space in the approved centre.</td>
<td></td>
</tr>
<tr>
<td>Project Team progress reports</td>
<td>Achievable</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>The medication discontinuation date was not documented in three cases, 23 (1). One entry in the MPAR was illegible, 23 (1).</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>Full medication audit is carried out every month by pharmacy, medical and nursing. Feedback provided to the teams.</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Full medication audit is carried out every month by pharmacy, medical and nursing. Feedback provided to the teams.</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Achievable</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>31/12/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Director of Nursing Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Full Monthly Medication Audit. Feedback of the audit provided to all medical team responsible for prescribing. Education sessions on Good Prescribing Practices provided to the NCHD group. Education sessions on Medication Management for Nursing Staff Pharmacist reviews MPARs daily - and reports discrepancy to relevant prescribers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>Full Monthly Medication audit. Education Sessions</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Full Monthly Medication audit. Education Sessions</td>
</tr>
<tr>
<td><strong>Achievable</strong></td>
<td>Achievable</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>31/12/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Clinical Director Director of Nursing</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Reason ID : 10000264**

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

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Mental Health Act 2001 - All staff to be directed to HSE Land for training. Certificates to be submitted to line manager for filing. Fire Safety - Regular training provided on site. All staff to be directed to attend training. Evacuation training arranged on a rolling basis through HSE fire officer. Basic Life Support - A schedule is being devised to provide staff with BLS training. TMVA - Continuous training programme. Children's First All staff directed to HSEland E-learning and submit certificate to management. Training plan maintained for staff. Regular review by management team. Training Calendar developed and circulated among all members of the MDT.</td>
<td>Attendance at each training session will be monitored via production of certificates and/or attendance records. Bi-Annual audit of training records. Deficits highlighted by the audit process will be addressed by senior management.</td>
<td>Achievable</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Mental Health Act 2001 - All staff to be directed to HSE Land for training. Certificates to be submitted to line manager for filing. Fire Safety - Regular training provided on site. All staff to be directed to attend training. Evacuation training arranged on a rolling basis through HSE fire officer. Basic Life Support - A schedule is being devised to provide staff with BLS training. TMVA - Continuous training programme. Children's First All staff directed to HSEland E-learning and submit certificate to management. Training plan maintained for staff. Regular review by management team. Training Calendar developed and circulated among all members of the MDT. | Attendance at each training session will be monitored via production of certificates and/or attendance records. Bi-Annual audit of training records. Deficits highlighted by the audit process will be addressed by senior management. | Achievable | 31/12/2019 | Senior Management Team |
| Continuous training programme. Children's First All staff directed to HSE and E-learning and submit certificate to management. Training plan maintained for staff. Regular review by management team. Training Calendar developed and circulated among all members of the MDT |   |   |   |
Regulation 27: Maintenance of Records

<table>
<thead>
<tr>
<th>Reason ID: 10000266</th>
<th>Not all records were maintained in a manner so as to ensure completeness and accuracy, 27 (1).</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></td>
<td>All MDT staff have been informed through education of the necessity for the need of two unique patient identifiers on all documentation in a patient's chart. Administrative staff monitor the medical record to ensure all documentation has two unique identifiers. Patient's identification stickers are provided with all charts. Prompts for Good Documentation will be circulated to the MDTs Any revised and new documentation will have a double identifier to ensure completeness and accuracy. Education sessions for Nursing on this regulation Induction programme for NCHDs now includes the processes in place for Regulation 27.</td>
<td>Audits increased to quarterly.</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Senior Management Meeting</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></td>
<td>All MDT staff have been informed through education of the necessity for the need of two unique patient identifiers on all documentation in a patient's chart. Administrative staff monitor the medical record to ensure all documentation has two unique identifiers. Patient's identification stickers are provided with all charts. Prompts for Good Documentation will be circulated to the MDTs Any revised and new documentation will have a</td>
<td>Quarterly audit</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Senior Management Meeting</td>
</tr>
</tbody>
</table>
double identifier to ensure completeness and accuracy. Education Sessions for nursing staff on this regulation Induction programme for NCHDs now includes the processes in place for Regulation 27.
### Regulation 28: Register of Residents

**Reason ID : 10000267**

<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>1) The register is in an electronic format since May 2019. When the patient status changes, this is highlighted via the MHC forms to the MHA Administrator who is responsible for ensuring the register is updated. 2) Provisional diagnosis is provided in the initial assessment is inputted onto the register of residents by clerical admin staff. • On completion of the discharge summary the register of residents is updated to include diagnosis on discharge. 3) The admission assessment form was amended to reflect provisional diagnosis on admission. • The admitting registrar records the diagnosis on admission using the ICD identification codes.</td>
<td>Audited every 6 months</td>
<td>Achievable</td>
<td>13/08/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>1) The register is in an electronic format since May 2019. When the patient status changes, this is highlighted via the MHC forms to the MHA Administrator who is responsible for ensuring the register is updated. 2) Provisional diagnosis is provided in the initial assessment is inputted onto the register of residents by clerical admin staff. • On completion of the discharge summary the register of</td>
<td>6 monthly audit</td>
<td>Achievable</td>
<td>13/08/2019</td>
</tr>
<tr>
<td>residents is updated to include diagnosis on discharge.  3) The amended admission assessment includes provisional diagnosis on admission. • The admitting registrar uses the ICD identification codes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### COP Relating to Admission of Children under the Mental Health Act 2001.

**Reason ID: 10000250**

i) Age-appropriate facilities and a programme of activities were not provided, 2.5 (b), ii) Children did not have access to age-appropriate advocacy facilities, 2.5 (g), and iii) The clinical file did not record the child's understanding of the explanation of their rights and information about the ward and facilities, 2.5 (h).

<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>
</table>
| 1) Age appropriate facilities now available through the Therapy Department. 2) Age appropriate advocacy facilities can be accessed through the CAMHS Linn Dara. 3) Child admission documentation amended to ensure that the Child's understanding is documented | Audit on this Code of Practice completed on every Child Admission and Discharge. Policy will be reviewed and amended to reflect access to advocacy. Audit on this Code of Practice completed on every Child Admission and Discharge. | Achievable            | 30/09/2019 | Clinical Director  
Director of Nursing |

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
</table>
| Continue to adhere to the Code of Practice and also continue to liaise with the CAMHS service. 1: A programme of Recreational activities, games/videos etc., are available where appropriate. 2: An | Audits are completed on every admission and on discharge of all children to Lakeview Unit Each Child admission is audited and provision of recreational activities is captured in each ICP. This is | Achievable            | 30/09/2019 | Director of Nursing  
Clinical Director |
<p>| advocacy service is available via the CAMHS Linn Dara 3: Amended admission checklist has been implemented | also subject to audit. |  |  |  |</p>
<table>
<thead>
<tr>
<th>Reason ID: 10000253</th>
<th>There was no named consultant anaesthetist with overall responsibility for anaesthesia, 11.2.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>To identify a named Lead Consultant Anaesthetist for ECT</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>Measurable</td>
</tr>
<tr>
<td>Documentation including ECT Checklist and ECT information booklet to be amended to ensure that the resident was informed of their rights.</td>
<td>Audit to be amended to reflect same. ECT Policy to be amended.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The named Lead Consultant Anaesthetist for ECT to be reviewed yearly as part of the policy review.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Documentation including ECT Checklist and ECT information booklet to be amended to ensure that the resident was informed of their rights.</td>
<td>Audit to be amended to reflect same. ECT Policy to be amended.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000254</th>
<th>A resident was not informed of their right to access an advocate, 4.6.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Documentation including ECT Checklist and ECT information booklet to be amended to ensure that the resident was informed of their rights.</td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td>Measurable</td>
</tr>
<tr>
<td>Audit to be amended to capture same</td>
<td>Audit to be amended to reflect same. ECT Policy to be amended.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>ECT amended documentation will ensure that the resident are informed of their rights</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Audit Policy Review</td>
<td>Audit to be amended to capture same. ECT Policy to be amended.</td>
</tr>
</tbody>
</table>
### Code of Practice on Admission, Transfer and Discharge to and from an approved centre

**Reason ID : 10000255**

Discharge plans did not include references to early warning signs of relapse and risk, 34.2. and Discharge summaries did not include details of mental state at discharge or risk issues such as signs of relapse, 38.4.

<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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICP is being amended to include early warning signs of relapse and risk. Discharge Information Leaflet is being development. Discharge safety management plan duplicate book to be devised and this will inform the discharge summaries Provisional diagnosis is provided in the initial assessment is inputted onto the register of residents by clerical admin staff. On completion of the discharge summary the register of residents is updated to include diagnosis on discharge. The admission assessment form was amended to reflect provisional diagnosis on admission. The admitting registrar records the diagnosis on admission using the ICD identification codes.</td>
<td>The discharge audit and ICP audit to be revised to ensure this information is captured</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation for this Code of Practice is being reviewed and amended to address this area of non-compliance Audit is amended to reflect these documentation changes</td>
<td>Code of Practice Audit</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Senior Management Team</td>
</tr>
</tbody>
</table>
### Code of Practice on the Use of Physical Restraint in Approved Centres

#### Reason ID: 10000275

<table>
<thead>
<tr>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>In one episode of physical restraint, a designated staff member was not identified as being responsible for leading the physical restraint or for monitoring the head and airway of the resident, 5.2.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Audit Real time review of documentation post an episode of physical restraint</td>
<td>Achievable</td>
<td>13/08/2019</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

#### Preventative Action

<table>
<thead>
<tr>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of Lead Person highlighted in TMVA training. Regular Regulation and Policy Training on this Code of Practice Any discrepancies in recording are addressed with individuals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Audit Real time review of documentation after each episode of physical restraint</td>
<td>Achievable</td>
<td>13/08/2019</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000276

<table>
<thead>
<tr>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>In one episode of physical restraint, the clinical practice form was not signed by a consultant psychiatrist within 24 hours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Audit Real time review of documentation after each episode of seclusion</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

#### Preventative Action

<table>
<thead>
<tr>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>A process for prompting the Consultant Psychiatrist has been implemented to ensure that Clinical Practice Forms are signed within 24 hours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Audits Real time review documentation</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000277

<table>
<thead>
<tr>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>In one episode of physical restraint, the resident was not informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint and no reason was given for not informing the resident, 5.8.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Audit Real time review of documentation after each episode of physical restraint</td>
<td>Achievable</td>
<td>13/08/2019</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Continuous staff education regarding Code of Practice on Physical Restraint. A process is being put in place to ensure alignment of documentation between restraint and seclusion pathways</td>
<td>Quarterly audit</td>
<td>achievable</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Continuous staff education regarding Code of Practice on Physical Restraint. A process is being put in place to ensure alignment of documentation between restraint and seclusion pathways</td>
<td>quarterly audit</td>
<td>Achievable</td>
</tr>
</tbody>
</table>

**Reason ID : 1000278**

Where a resident had consented, the resident's representative was not informed of the use of physical restraint, with no reason recorded in the clinical file, 5.9(a).

<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>Corrective Action</td>
<td>Continue education on the Code of Practice for Physical Restraint</td>
<td>Quarterly Audit</td>
<td>Achievable</td>
<td>30/09/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Continue education on the Code of Practice for Physical Restraint</td>
<td>Real time documentation review post each episode of physical restraint. Audited quarterly</td>
<td>Achievable</td>
<td>30/09/2019</td>
</tr>
</tbody>
</table>
### Rules Governing the Use of Seclusion

<table>
<thead>
<tr>
<th>Reason ID: 10000272</th>
<th>The seclusion room was used as a bedroom, 8.4.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Continue use of Allied Admissions to transfer voluntary patient to other approved centre when beds are available. Sourcing beds in both public and private approved centres. The proposed new build will have a bed capacity that will service the population needs of the catchment area. Continuous care bed management in order to reduce numbers of long stay patients where possible and monitor same. Active case management of patients who may need continuing care. Use of the SRU for those who need specialist rehabilitation. Continue to access up to 10 beds in Portlaoise. Monthly report of bed occupancy will be circulated to SMT and also local QPS Committee.</td>
<td>Bed availability is reviewed and managed daily. Overcapacity is measure through the submissions of the MHC Overcapacity form since Jan 2019</td>
</tr>
</tbody>
</table>

| Preventative Action |  |  |
|---------------------|-----------------|-----------------|----------------|------------------|
| **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| Bed availability is reviewed and managed daily. Continue sourcing beds in both public and private approved centres. | Overcapacity is measure through the submissions of the MHC Overcapacity form since Jan 2019 | Achievable | 31/12/2019 | Senior Management Team |

<table>
<thead>
<tr>
<th>Reason ID: 10000273</th>
<th>The seclusion register not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours, 3.5.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td>Prompt system now in place since inspection 2019 to ensure timely signatures on Seclusion Register.</td>
<td>Real time documentation reviews post each episode</td>
</tr>
</tbody>
</table>
### Preventative Action
Prompt system now in place since inspection 2019 to ensure timely signatures on Seclusion Register.

| Seclusion Audit | Real time review of documentation post a seclusion episode | Achievable | 13/08/2019 | Clinical Director |

### Reason ID: 10000274
One resident was not informed of the ending of an episode of seclusion, 7.3.

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Seclusion pathway will be followed. On-going education on the Code of Practice of Seclusion and documentation for all clinical staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Seclusion pathway will be followed. On-going education on the Code of Practice of Seclusion and documentation for all clinical staff.</td>
<td>Quarterly audit</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Seclusion pathway will be followed. On-going education on the Code of Practice of Seclusion and documentation for all clinical staff.</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

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

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

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

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

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

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

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

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

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

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