Maryborough Centre, St. Fintan’s Hospital

ID Number: AC0008

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Maryborough Centre, St. Fintan’s Hospital
Dublin Road
Portlaoise
Co Laois

Conditions Attached: Yes

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

Most Recent Registration Date: 17 May 2019

Registered Proprietor: HSE

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

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Mary Conellan
Martin McMenamin

Inspection Date: 02 – 05 July 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 29 May – 1 June 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Friday 28 February 2020

2019 COMPLIANCE RATINGS

REGULATIONS

<table>
<thead>
<tr>
<th>Compliant</th>
<th>Non-compliant</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

RULES AND PART 4 OF THE MENTAL HEALTH

<table>
<thead>
<tr>
<th>Compliant</th>
<th>Non-compliant</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

CODES OF PRACTICE

<table>
<thead>
<tr>
<th>Compliant</th>
<th>Non-compliant</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

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

2.0 Quality Initiatives .................................................................................................................. 8

3.0 Overview of the Approved Centre ............................................................................................ 9
   3.1 Description of approved centre ............................................................................................ 9
   3.2 Governance .......................................................................................................................... 9
   3.3 Reporting on the National Clinical Guidelines ............................................................... 10

4.0 Compliance ............................................................................................................................... 11
   4.1 Non-compliant areas on this inspection ............................................................................ 11
   4.2 Areas of compliance rated “excellent” on this inspection ............................................. 11
   4.3 Areas that were not applicable on this inspection .......................................................... 12

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

6.0 Feedback Meeting .................................................................................................................. 12

7.0 Inspection Findings – Regulations .......................................................................................... 12

8.0 Inspection Findings – Rules ................................................................................................... 54

9.0 Inspection Findings – Mental Health Act 2001 .................................................................... 54

10.0 Inspection Findings – Codes of Practice .......................................................................... 55

Appendix 1: Corrective and Preventative Action Plan .................................................................. 60

Appendix 2: Background to the inspection process ................................................................. 74
1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The Maryborough Centre was on the ground floor on the grounds of St. Fintan’s Hospital, Portlaoise. It was the only inpatient facility at St. Fintan’s hospital which was a nineteenth century psychiatric hospital. The approved centre was located alongside a child and adolescent service, primary care services and two other mental health services. The approved centre was registered for 28 beds and provided continuing care, psychiatry of later life and mental rehabilitation services for the Laois/Offaly area. The approved centre was under the governance of the Midlands Louth Meath Community Healthcare Organisation.

Over the past three years, compliance with regulations and codes of practice has improved from 64% in 2017 to 83% in 2019. In 2018, compliance was 91%. Twelve compliances with regulations were rated as excellent.

Conditions to registration

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

Condition 1: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Safety in the approved centre

- Food safety audits had been completed periodically and food temperatures were recorded in line with food safety recommendations. There was suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, and serving of food. Hygiene was maintained to support food safety requirements, and associated catering and food safety equipment were appropriately cleaned.
- The ordering, prescribing, storage and administration of medication were carried out in a safe manner.
However:

- Not all health care professionals were up-to-date with required mandatory training to include Fire Safety, Basic Life Support, the Mental Health Act and Therapeutic Management of Violence and Aggression or equivalent.

**Appropriate care and treatment of residents**

- For residents on antipsychotic medication there was evidence of an assessment of glucose regulation, blood lipids and prolactin. These residents had also had an Electrocardiogram (ECG).

However:

- There were deficits in the individual care plans for residents:
  - One ICP did not contain appropriate goals for the resident.
  - One ICP did not contain appropriate care and treatment for the resident.
  - Five ICPs did not adequately identify the resource required to provide the care and treatment.
  - Three ICPs were not developed by the MDT.
  - Two ICPs were not developed within 7 days of admission.
- There was no psychology input and very limited occupational therapy input for residents at the time of inspection. There was no designated Occupational Therapy post in the Maryborough centre; this post was awaiting approval under development funding. Two occupational therapists from other services covered Maryborough centre as occupational therapy needs arose.
- Social work or psychology were not involved with the therapeutic programme.
- The clinical file of one resident who had been admitted to the approved centre was inspected. The admission assessment documentation was only partially completed. There was an account of the presenting problem but the assessment did not document the residents past psychiatric history, family history, medical history, current and historic medication or any other relevant information.
- General health assessments for five residents were not all fully completed. Four of the five did not have the family/personal history sections completed, one out of five did not have the smoking status for the resident documented. A further one did not have the nutritional status documented with minimal information recorded thereafter. One of five did not have the dental health assessment documented. All five had ‘as per kardex’ for medication review, with no indication that medication had been reviewed.
- Adequate arrangements were not in place for residents to access general health services and for their referral to other health services, as required, on the days of the inspection. Physical health needs had previously been provided by a general practitioner. This service ceased a few weeks prior to the inspection and processes were not yet in place to address this issue.
Respect for residents’ privacy, dignity and autonomy

- Residents wore clothing that respected their privacy and dignity. The approved centre’s layout and furnishings were conducive to resident privacy and dignity. Single rooms did not have locks on the inside of the door, but this was for health and safety reasons. Where residents shared a room, appropriate bed screening was in place to ensure that resident privacy was not compromised.

- There was a cleaning schedule implemented within the approved centre, and the approved centre was clean, hygienic, and free from offensive odours. The approved centre was kept in a good state of repair externally and internally. There was a documented programme of general maintenance, decorative maintenance, decontamination, and repair of assistive equipment and records were maintained. Back-up power was available to the approved centre.

- There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre and the CCTV cameras were incapable of recording or storing a resident’s image.

Responsiveness to residents’ needs

- Menus had been approved by a dietitian and residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals and food, including modified consistency diets. The modified consistency diets while considered to be tasty were not attractive and appealing in presentation.

- Residents had access to a range of appropriate recreational activities. These included walks, weekend outings, softball hoops and rings, chair yoga, music, art, baking and relaxation groups. Some residents attended a resource centre locally. They had access to an outdoor garden that provided a safe walking route and adequate shelter and there was access to transport. There was a dedicated activities room and a large day room where activities were also held.

- There was adequate written information for residents about the approved centre, medication and diagnosis.

- There was an excellent complaints procedure in place.

Governance of the approved centre

- The approved centre was under the governance of the Laois/Offaly Mental Health Services and within the overall governance of the Midlands Louth Meath Community Healthcare Organisation. A Mental Health Leadership group met every two months. This was attended by the head of service, registered proprietor, and various departmental managers. Agenda items included National Key Performance Indicators, CHO projects, QPS, finance and human resources issues. At an area level, took place on a monthly basis. Standing agenda items pertained to operational, quality and clinical governance issues.

- Risks were discussed at the monthly Laois/Offaly Senior Management Team/Quality Patient Safety meetings and were included in the risk register, where appropriate. Where required, the Risk and Patient Safety Advisor provided advice and support to the service in relation to risk management issues.
• Performance appraisals were not generally used within disciplines.
• Staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training.
• There were regular resident community meetings. Feedback was sought from families and carers at organised meetings in the approved centre and via a ‘Family Meeting Form’ for those who could not attend.
• Operating policies and procedures were developed by the Policy Working Group with input from clinical and management staff and relevant stakeholders.
• Systems in place to support quality improvement included a programme of audit; however, not all disciplines were involved in the audit process. The majority of audits were undertaken by the nursing team.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:


2. The approved centre’s Advanced Nurse Practitioner in dementia care began attending morning handover to offer expertise and advice to staff when required.

3. The approved centre has established a staff coordinator to increase resident, carer and family involvement in the individual care plan (ICP) process.

4. Where families were not able to attend meetings regarding the residents, staff sought their input by asking them to complete a family meeting form.

5. A patient satisfaction questionnaire has been developed for residents being discharged from the approved centre.

6. The inside of the approved centre had recently been painted and a fence had been erected in the garden area to improve resident safety.

7. The approved centre continued to establish a home-like environment by introducing safe fire stoves to the communal area.

8. Life story work had re-commenced for the residents. This framework was used by staff to help them deliver person-centred care.

9. One staff member was currently undertaking Sonas training. The Sonas programme focuses on therapeutic activities for people living with dementia.

10. An intergenerational music group had commenced to encourage residents to partake in music activities.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Maryborough Centre was on the grounds of St. Fintan’s Hospital, Portlaoise. The approved centre was located on the ground floor; it was formerly known as Ward 6. Although the only inpatient facility at St Fintan’s hospital, the approved centre was located alongside a child and adolescent service, primary care services and two other mental health services. The approved centre was registered for 28 beds and provided continuing care, psychiatry of later life and mental rehabilitation services for the Laois/Offaly area. The approved centre was under the governance of the Midlands Louth Meath Community Healthcare Organisation.

Accommodation for residents comprised of four bed, two bed and single bed rooms. Resident bedrooms were personalised, and they were clean and bright. Communal areas were comfortable, very spacious and there was plenty of orientation signage in the approved centre to help residents negotiate their environment. The dining room was bright, spacious and inviting. Residents in the approved centre had access to a secure, dementia friendly garden.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>28</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>24</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>22</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was under the governance of the Laois/Offaly Mental Health Services and within the overall governance of the Midlands Louth Meath Community Healthcare Organisation. A Mental Health Leadership group met every two months. This was attended by the head of service, registered proprietor, and various departmental managers. Agenda items included National Key Performance Indicators, CHO projects, QPS, finance and human resources issues. At an area level, the Laois/Offaly Senior Management Team/Quality Patient Safety meetings (SMT/QPS) took place on a monthly basis. Standing agenda items pertained to operational, quality and clinical governance issues. Minutes of these meetings were made available to the inspection team.

Risks were discussed at the monthly SMT/QPS meetings and were included in the risk register, where appropriate. The approved centre provided the inspection team with a copy of the risk register. Not all
issues which had been identified by the approved centre’s senior nursing team had been included in the risk register. Where required, the Risk and Patient Safety Advisor provided advice and support to the service in relation to risk management issues.

The inspection team received five completed Governance Questionnaires from the Senior Management Team and during the inspection sought to meet with the Clinical Director and Area Director of Nursing. Feedback suggested that management visited the approved centre regularly. Challenges with regard to lack of staff was seen as a risk for the approved centre. Performance appraisals were not generally used within disciplines; however, performance was appraised through supervision and team meetings. It was noted that there was no dedicated psychologist for the approved centre. This post has been approved and was yet to be filled. Occupational therapy and social work services were provided on a referral basis. Physical health needs had previously been provided by a general practitioner. This service ceased a few weeks prior to the inspection and processes were not yet in place to address this issue. The inspection team has since been assured that the non-consultant hospital doctors (NCHDs) will provide this service along with regular reviews of the resident’s mental health needs.

Staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident, families and carer involvement in the process of quality improvement. Feedback was sought from families and carers at organised meetings in the approved centre and via a ‘Family Meeting Form’ for those who could not attend. Residents also had access to advocacy services if required; advocacy contact details were displayed within the approved centre.

Operating policies and procedures were developed by the Policy Working Group with input from clinical and management staff and relevant stakeholders.

Systems in place to support quality improvement included a programme of audit; however, not all disciplines were involved in the audit process. The majority of audits were undertaken by the nursing team.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management</td>
<td>X</td>
<td>High</td>
<td>✓</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

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

### 5.0 Service-user Experience
The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team 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 inspectors met with one resident and two family members. Four completed service user experience questionnaire were returned. All comments were very complimentary of the staff and the care and treatment provided. Residents and their relatives were happy with the food and food choices, and their accommodation. The completed questionnaires indicated that the residents were involved in their care planning, knew their mental healthcare team and were always able to discuss worries or concerns with a member of staff. One resident mentioned that there were not enough activities; however, they did not give any further details. All others respondents were very happy with the care and treatment.

Feedback was not received from the IAN regarding the approved centre.
6.0 Feedback Meeting

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

- Area Director of Nursing
- Business Manager
- Executive Clinical Director
- Principal Psychologist
- Senior Occupational Therapist
- Clinical Nurse Manager 3
- Clinical Nurse Managers 2 x 2
- Advanced Nurse Practitioner
- Clinical Nurse Specialist
- Principal Social Worker

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. There was discussion around the role of the newly appointed OT and the vacant psychology post.
The following regulations are not applicable

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

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

**INSPECTION FINDINGS**

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

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

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

**Evidence of Implementation:** A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The preferred identifiers were detailed within the residents’ clinical files. Along with name and date of birth these included photograph identification and a unique hospital number for each resident. Identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, providing health care services and therapeutic services and programmes. There was no alert system for identifying residents with the same or a similar name.

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 5: Food and Nutrition

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

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

### INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** Menus had been approved by a dietitian and residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals and food, including modified consistency diets. The modified consistency diets while considered to be tasty were not attractive and appealing in presentation. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times. Hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was used for residents with special dietary requirements. Where appropriate, weight charts were implemented, monitored, and acted upon. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian and intake and output charts were maintained, where appropriate. Nutritional and dietary needs were assessed.

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 6: Food Safety

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). This was documented.

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

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. There was suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, and serving of food. Food was prepared and cooked in the main kitchen of the Midlands Regional Hospital and transported to the approved centre.

Hygiene was maintained to support food safety requirements, and associated catering and food safety equipment were appropriately cleaned. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, was last updated in 2018. The policy included of the requirements of the Judgement Support Framework.

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. A record of residents wearing nightclothes during the day, as indicated by their ICP, was kept and monitored.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs and residents had access to on-site laundry facilities. Emergency clothing was available if it was required. Residents changed out of nightclothes during the day unless in their individual care plan. All residents had an adequate supply of individualised clothing.

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

COMPLIANT
Quality Rating: Excellent

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in December 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The registered proprietor ensured that each resident retained control of their property and possessions except under circumstances where this posed a threat to the resident or others as indicated by the resident’s individual care plan. Secure facilities were provided for the safekeeping of valuables and personal effects. Access to and use of resident monies was overseen by two staff members and, when possible, the resident or their representative.

Each resident had their own wardrobe and locker. Individual property checklists were maintained. These were filed separately to each resident’s individual care plan and were available to residents.

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

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

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

**Evidence of Implementation:** Residents had access to a range of appropriate recreational activities. These included walks, weekend outings, softball hoops and rings, chair yoga, music, art, baking and relaxation groups. Some residents attended a resource centre locally. Residents had access to an outdoor garden that provided a safe walking route and adequate shelter. Fencing had been added since the last inspection to minimize health and safety risks. Recreational activities were facilitated on weekdays and during the weekend, and they were developed and implemented with resident involvement. The approved centre had access to transport. There was a dedicated activities room and a large day room where activities were also held.

Where appropriate, individual risk assessments had been completed for residents in relation to the selection of activities. Residents’ decisions on whether or not to participate in activities were respected and documented. Documented records of attendance were retained both within group records and the resident’s clinical file.

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

**COMPLIANT**

**Quality Rating:** Excellent
Regulation 10: Religion

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were facilitated to practice their religion insofar as was practicable. There was a church on the grounds and mass was celebrated weekly. If required, residents had access to multi-faith chaplains. A Roman Catholic Priest and Church of Ireland Minister regularly visited the approved centre.

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: There were no restrictions on residents’ rights to receive visitors. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed and were appropriate and reasonable. There were no visiting restrictions for any of the residents. A separate visitors’ room was located near the entrance to the approved centre and was suitable for visiting children. Visitors were requested to sign a visitors’ book. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety.

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Resident communication needs 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 a range of communications, including telephone, internet and email. When necessary, individual risk assessments were completed for residents with regard to their communication. Where appropriate the clinical director or senior staff member designated examine resident internal and external communication.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

As no search had been conducted in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not applicable.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and protocols in relation to care of the dying. The policies were last reviewed in July 2019. The policies and protocols addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: End of life care provided to residents was reviewed to ensure section 2 of the regulation had been complied with. There had been no sudden or unexpected deaths in the approved centre since the last inspection. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: Five residents had died in the approved centre since the last inspection. The clinical file of one resident who had died was reviewed. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of the resident, who was nursed in a single room. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Palliative care was prioritised and the palliative care team attended as required. A Do Not Attempt Resuscitation (DNAR) order and associated discussions were documented when applicable in the clinical file.

Support was given to other residents and staff following a resident’s death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

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 15: Individual Care Plan

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use and review of individual care plans (ICPs), which was last reviewed in November 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: 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. 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 ICPs were maintained as one composite set of documents that included spaces or sections for goals, treatment, care and resources required. There was a space for reviews and they were stored in the clinical file separate from the progress notes.

Ten ICPs were inspected. Each resident had an initial assessment; however, for two of the ten inspected, the ICP had not been developed within seven days of admission. Three of the ICPs inspected were not developed by the MDT. Comprehensive assessments had been completed for each resident using evidence based assessments. The ICP was drawn up involving the resident and when a resident was unable to participate there was evidence in the documentation to indicate that the relatives had been involved in the process on behalf of the resident.

The ICP’s did identify assessed needs, although three of the four teams did not have a psychologist on the team. One ICP did not include appropriate goals for that resident. The care and treatment required was documented for all but one of the ten ICP’s inspected. The resource required to provide care and treatment was not adequately identified in five of the ICPs inspected. A preliminary discharge plan was not identified in 3 of the ICPs.

A keyworker had been identified for each resident to ensure continuity in the implementation of the ICP. Each ICP included a risk management plan. A review had been undertaken at least six monthly. The resident had access to their ICP and was kept informed of any changes. The resident had been offered a copy of their ICP including reviews and when a resident declined or refused a copy this had been documented.
The approved centre was non-compliant with this regulation for the following reasons:

a) One ICP did not contain appropriate goals for the resident.
b) One ICP did not contain appropriate care and treatment for the resident.
c) Five ICPs did not adequately identify the resource required to provide the care and treatment.
d) Three ICPs were not developed by the MDT.
e) Two ICPs were not developed within 7 days of admission.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in August 2016. The policy addressed all the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The therapeutic services and programmes that were provided were appropriate and evidence based. They met the assessed needs of the residents, as documented in their individual care plans.

A list of therapeutic services and programmes provided in the approved centre was available to residents. Adequate resources were not available to provide therapeutic services and programmes which took place in a separate dedicated room that contained facilities and space for both individual and group therapies. There was no psychology input and very limited occupational therapy input at the time of inspection. There was no designated occupational therapy post in the Maryborough centre; this post was awaiting approval under development funding. Two occupational therapists from other services covered Maryborough centre as occupational therapy needs arose. Social work or psychology were not involved with the therapeutic programme. Therapeutic programmes were led by an Activities Nurse. Residents had access to a psychologist, a social worker, a dietitian, a physiotherapist and a speech and language therapist on referral.

A record was maintained of participation and engagement in therapeutic services in the residents’ individual care plan; this documentation also recorded the outcomes achieved.

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 18: Transfer of Residents

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The file of a resident who had been transferred to a general hospital was examined. Communication records with the receiving facility were documented and available on inspection, including agreement of resident prior to transfer. Verbal communication and liaison took place between and the receiving facility prior to the resident transfer. This included a discussion of the reasons for transfer, the resident’s care and treatment plan and the resident’s accompaniment requirements on transfer. Documented consent of resident transfer was available. An assessment of the resident was completed prior to the transfer and this included a risk assessment. Full and complete written information regarding care delivered was transferred when the resident moved to the receiving facility.

The following information was issued as part of the transfer documentation: the letter of referral, the resident transfer form, the required medication for the resident during the transfer process. A checklist was completed by the approved centre to ensure that comprehensive records were transferred to the receiving facility. Copies of all records relevant to the resident transfer were retained in a specific section within the resident’s clinical file.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had 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 March 2017. The medical emergencies policy was last reviewed in April 2018. The policies and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator, which had been checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents’ physical health on admission. On the days of the inspection there were inadequate medical arrangements to manage the residents’ ongoing general health needs. This was subsequently addressed by the approved centre.

At a minimum, a six-monthly health assessment had been completed. The general health assessments for five residents were inspected. These were not all fully completed. Four of the five did not have the family/personal history sections completed, one out of five did not have the smoking status for the resident documented. A further one did not have the nutritional status documented with minimal information recorded thereafter. One of five did not have the dental health assessment documented. All five had ‘as per kardex’ for medication review, with no indication that medication had been reviewed.

For residents on antipsychotic medication there was evidence of an assessment of glucose regulation, blood lipids and prolactin. These residents had also had an Electrocardiogram (ECG). Adequate arrangements were not in place for residents to access general health services and for their referral to other health services, as required, on the days of the inspection. This was addressed by the management following the inspection. National screening information was available, and residents could access...
national screening programmes, as applicable to resident needs. Residents had access to smoking cessation programmes and support.

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

a) Adequate arrangements had not been in place for access by residents to general health services, 19(1) (a)

b) The six-monthly assessments were incomplete, 19(1)(b).
Regulation 20: Provision of Information to Residents

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

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

INSPECTION FINDINGS

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

Training and Education: 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. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre’s information booklet that detailed the care and services provided. This booklet was available in the required formats to support residents’ needs and was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents’ rights.

Residents were provided with details of their multi-disciplinary teams. Residents were provided with written and verbal information on diagnosis, unless, in the treating psychiatrists’ view the provision of such information might be prejudicial to the residents’ well-being. Information was provided to residents on the likely adverse effects of treatment including risks and other potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to residents’ needs. The information provided within the approved centre was evidence based and was appropriately reviewed prior to use. Residents had access to interpretation and translation services if required.

The approved centre was compliant with this regulation. The quality assessment was 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 March 2017. The policy addressed requirements of the Judgement Support Framework, with the exception of the approved centre’s process for addressing a situation where resident privacy and dignity was not respected by staff.

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

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

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Residents wore clothing that respected their privacy and dignity. The approved centre’s layout and furnishings were conducive to resident privacy and dignity. Single rooms did not have locks on the inside of the door, but this was for health and safety reasons. Where residents shared a room, appropriate bed screening was in place to ensure that resident privacy was not compromised. Rooms were not overlooked by public areas. Public noticeboards did not display residents’ names or any identifiable information.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in May 2017. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:
   - The provision of adequate and suitable furnishings in the approved centre.
   - The identification of hazards and ligature points in the premises.

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

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

Evidence of Implementation: Residents had access to personal space and the approved centre provided appropriately sized communal rooms. There was a sufficient number of toilets and showers for residents in the approved centre. There was at least one assisted toilet. The premises were adequately lit, heated, and ventilated. Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs and slippery floors were minimised. Ligature points were minimised to the lowest practicable level, based on risk assessment.

There was a cleaning schedule implemented within the approved centre, and the approved centre was clean, hygienic, and free from offensive odours. The approved centre was kept in a good state of repair externally and internally. There was a documented programme of general maintenance, decorative maintenance, decontamination, and repair of assistive equipment and records were maintained. Back-up power was available to the approved centre.
There was a designated sluice room, cleaning room and laundry room. The approved centre had a dedicated examination room and all the resident bedrooms were appropriately sized to address their needs. Suitable furnishings had been provided to support resident independence and comfort. As required, appropriate assisted devices and equipment had been provided. Remote and isolated areas of the approved centre were monitored.

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

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


INSPECTION FINDINGS

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

Training and Education: All nursing and medical staff had signed the signature log to indicate that they had read and understood the policies. 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 policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

Evidence of Implementation: An MPAR was maintained for each resident that detailed two appropriate identifiers, a record of any allergies or sensitivities and the generic names of medications prescribed. There were dedicated spaces for routine medications, once-off medications and ‘as required’ (PRN) medications. The frequency, dose and administration route were included for each prescription. There were clear records of the dates of initiation and discontinuation for each medication, including the medical council registration number and signature of every medical practitioner prescribing. There was a record of all medications administered to the residents.

The entries in the MPARs were legible and written in black, indelible ink. Medication had been reviewed and rewritten at least every six months. All medication had been administered by a registered nurse or registered medical practitioner. No residents were self-administering medication at the time of inspection. Where a resident’s medication was withheld, the justification was noted in the MPAR and documented in the clinical file. Directions to crush medication were only accepted from the medical practitioner and the reasons were documented. The pharmacist was consulted about directions to crush medication.

Medication had been stored appropriately and storage areas were clean. A log of temperature of the refrigeration storage unit had been taken and documented daily. Medication was stored securely in a locked unit and scheduled 2 and 3 controlled drugs were kept locked in a separate cupboard. A system of stock rotation was implemented and an inventory of all medications was conducted on a monthly basis. Medications that were no longer in use had been returned to the pharmacy for disposal.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of theJudgement Support Framework.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in March 2017. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- Raising awareness of residents and their visitors to infection control measures.
- Covering of cuts and abrasions.
- Availability of staff vaccinations and immunisations.

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2017. The policy addressed requirements of the Judgement Support Framework, including the purpose and function of using CCTV for observing residents in the approved centre. The policy did not include requirements in relation to the maintenance of CCTV cameras by the approved centre.

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

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

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV was used solely for the purpose of observing a resident by health professionals who were responsible for their welfare and solely for the purpose of ensuring health, safety and welfare. The use of CCTV had been disclosed to the Mental Health Commission and the CCTV cameras were incapable of recording or storing a resident’s image. CCTV was not used to monitor a resident if they acted in a way which compromised their dignity.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to its staffing requirements. The policies were last reviewed in August 2016 with an update in 2018. The policies and procedures addressed 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 policies and procedures did not address staff performance and evaluation requirements.

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had not 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 lines of authority and accountability of the approved centre’s staff. There was a planned nursing staff rota, showing the nursing staff on duty both day and night. The numbers and skill mix of staff was not sufficient to meet the resident needs. There was minimal input from occupational therapy and there was no psychology input.

Staff were recruited, selected and vetted in accordance with the approved centres policies and procedures. Staff had appropriate qualifications to do their jobs and an appropriately qualified nursing staff member was on duty and in charge at all times. There was no written staffing plan for the approved centre. There was a minimum required number of nursing staff on duty at night to ensure safety of residents in the event of a fire or other emergency. Agency staff were used and there was a comprehensive agreement between the approved centre and the agency. This set out the agency’s responsibilities in...
relation to vetting of staff, confirmation of registration, confirmation of identity, professional indemnity and confirmation of staff training.

Annual training plans had been completed for all staff. Orientation and induction training was provided for new staff. Not all health care professionals were up to date with required mandatory training to include Fire Safety, Basic Life Support, the Mental Health Act and Therapeutic Management of Violence and Aggression or equivalent. The following is a table of staff mandatory training levels in the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (15)</td>
<td>12</td>
<td>13</td>
<td>13</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Consultant Psychiatrist (2)</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Medical (2)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Occupational Therapist (0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Staff were trained in line with the assessed needs of the resident group profile and training included manual handling, infection control and prevention, dementia care, end of life care, residents’ rights, care for residents with an intellectual disability, risk management, incident reporting and protection of children and vulnerable adults. All staff training was documented and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education. In-service training was completed by appropriately trained and competent individuals. Suitable facilities and equipment was available.

The Mental Health Act 2001, and associated regulations and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation was available in the approved centre.

The following is a table of clinical staff assigned to the approved centre.
The approved centre was non-compliant with this regulation for the following reasons:

a) The number and skill of staff was not appropriate to the assessed needs of the residents, 26(2).

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

c) Not all healthcare professionals had completed the mandatory Mental Health Act training, 26(5).

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryborough Centre</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>MTA</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>Referral</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>Referral</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

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

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

 Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff had been trained in best-practice record keeping.

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

 Evidence of Implementation: Residents’ records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured from loss or destruction, tampering, and unauthorised access or use. A record was initiated for each resident assessed and resident records were reflective of the residents’ current status and care and treatment being provided. Resident records were maintained using an identifier that was unique to the resident. Records were developed and maintained in a logical sequence. It was noted that a large number of polypockets were used within the files.

 Resident records were accessible to authorised staff only, and only these staff made entries into the resident records. Staff had access to the data and information necessary to carry out their responsibilities. Residents’ access to their records was managed in accordance with the Data Protection Acts.
Resident records were maintained appropriately. Entries were factual, consistent and did not contain jargon. Each entry included the date and noted the time using the 24-hour clock. Two appropriate resident identifiers were recorded on all documentation. Records were appropriately secured throughout the approved centre from loss or destruction, tampering and unauthorised access or use.

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

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

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained 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 not been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

**Evidence of Implementation:** The operating policies and procedures of the approved centre were developed by clinical and management staff with input from relevant stakeholders. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Operating policies and procedures were communicated to all relevant staff.

All of the operating policies and procedures required by the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Generic policies in use 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, adopting the policies in question.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A nominated individual with responsibility for dealing with complaints was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All complaints were documented and dealt with by the nominated complaints officer or directly by staff receiving the complaint. There was a method for addressing minor complaints within the approved centre and minor complaints were documented.

COMPLIANT

Quality Rating: Excellent
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 May 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The risk register was not reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.
Evidence of Implementation: Responsibilities were allocated at management level to ensure the effective implementation of risk management. The person with responsibility for risk was known by staff in the approved centre. Risk management procedures actively sought to reduce identified risks to the lowest practicable level of risk. Clinical risks and health and safety risks were identified, assessed, treated, reported and monitored, however, they had not been documented in the risk register, when deemed appropriate, as per the approved centre’s policy. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported and monitored. These had been documented in the risk register.

Individual risk assessments had been completed prior to and during physical restraint, on admission, resident transfer and discharge and in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Incidents in the approved centre were recorded and risk-rated using the National Incident Management System. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. The approved centre had an emergency plan that incorporated fire evacuation procedures.

The approved centre was non-compliant with this regulation because not all clinical and health and safety risks identified by the approved centre, had been documented on the risk register, 32(1).
## Regulation 33: Insurance

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

### INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
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. The policy had been reviewed annually and was dated January 2019. It addressed the following:

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

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

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

Evidence of Implementation: Physical restraint was used in rare and exceptional circumstances within the approved centre, and in these cases only after all alternative interventions to manage the residents’ unsafe behaviour had been considered. Any use of physical restraint was based upon risk assessment and cultural awareness and gender sensitivity were demonstrated at all times.

Three episodes of physical restraint were reviewed as part of the inspection process. In each episode the physical restraint had been initiated by a registered nurse. A designated staff member was responsible for leading the physical restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and the registered medical practitioner completed a medical examination of the resident (physical examination) no later than three hours after the start of the episode of restraint. A Clinical Practice Form was completed by the staff member initiating and ordering physical restraint within the required 3 hour timeframe; this form was signed by the consultant psychiatrist within 24 hours.

The residents’ were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. As soon as was practicable the residents’ next of kin was informed of the use of physical restraint and this communication was recorded within the clinical file. The residents’ were afforded the opportunity to discuss the episode with members of their multi-disciplinary team (MDT) as soon as was practicable and each episode had been reviewed by members of the respective MDT no later than two working days. Completed clinical practice forms had been placed in the residents’ clinical files.

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

**INSPECTION FINDINGS**

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

**Admission:** The admission policy, which was last reviewed in September 2017 addressed all of the required policy-related criteria for this code of practice. These included a procedure for involuntary admission and protocols for planned admission with reference to pre-admission assessment, eligibility for admission and referral letters. There was a policy on privacy, confidentiality and consent.

**Transfer:** The transfer policy, which was last reviewed in May 2017, included all of the required policy-related criteria for this code of practice.

**Discharge:** The discharge policy, which was last reviewed in September 2017 included procedure for discharge of involuntary patients, a protocol for discharging homeless people and procedures for managing discharge against medical advice.

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

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

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

**Admission:** The clinical file of one resident who had been admitted to the approved centre was inspected. The approved centre had a key worker system in place. The decision to admit was made by the Registered Medical Practitioner (RMP). The resident was assessed on admission but the admission assessment documentation was only partially completed. There was an account of the presenting problem but the assessment did not document the residents past psychiatric history, family history, medical history, current and historic medication or any other relevant information. The social and housing circumstances, current mental state and risk assessment were assessed and documented. A full physical examination had been completed. It was not evident from the documentation if the resident’s family member/carer/advocate had been involved in the admission process with resident consent.

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

**Discharge:** The clinical file of a resident who had been discharged was reviewed. The resident’s individual care plan contained a discharge plan. The resident was comprehensively assessed prior to discharge and the discharge had been coordinated by the key worker. There was documented communication with the relevant personnel that included a follow up plan but the discharge plan did not include reference to early warning signs of relapse and risk. The community mental health team/primary care team was informed of the discharge within three days. A discharge summary was sent within 14 days but this was not
comprehensive and did not include details in relation to prognosis, mental state at discharge, follow up arrangements, names and contact details of key people for follow up or risk issues such as signs of relapse. Details relating to family member/carer/advocate involved in the discharge were not documented. Details relating to a follow up appointment were not documented in the discharge summary.

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

- a) An admission assessment had not been fully completed, 15.1
- b) The assessment did not include details regarding past psychiatric history, family history, current and historic information, medical history or any other relevant information, 15.3
- c) It was not known from the documentation if the resident’s family member/carer/advocate had been involved in the admission process with resident’s consent, 18.3
- d) The discharge plan did not include reference to early warning signs of relapse and risks, 34.2
- e) A comprehensive discharge summary was not issued within 14 days, 38.3(b).
- f) The discharge summary did not include details of prognosis, mental state on discharge, follow up arrangements, names and contact details of key people for follow-up or risk issues such as signs of relapse, 38.4
- g) Details relating to family member/carer/advocate involved in the discharge were not documented, 39.1
- h) Details relating to a timely follow up appointment were not documented, 41.1(c).
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 15: Individual Care Plan

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>One ICP did not contain appropriate goals for the resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific: ICP training sessions have been arranged for the Team for mid January 2020 to address this area of non compliance and the importance for appropriate goals and actions. Measurable: Audits of the ICP will be completed following the training sessions and quarterly throughout the year. Achievable/Realistic: Achievable. Time-bound: 31/03/2020. Post-Holder(s): Consultants, Heads of Discipline and ICP coordinator.</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Specific: Audits of the ICP’s will capture any area’s of non Compliance. Measurable: ICP's will be audited quarterly to ensure that the ICP’s now comply with the Regulation. Achievable/Realistic: Achievable. Time-bound: 31/03/2020. Post-Holder(s): Consultants, Heads of Discipline and ICP coordinator. |

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>One ICP did not contain appropriate care and treatment for the resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific: ICP training is scheduled for the team in Mid January this will address this specific area of non compliance. Measurable: ICP's will be audited quarterly to ensure that the ICP’s now comply with the Regulation. Achievable/Realistic: Achievable. Time-bound: 31/03/2020. Post-Holder(s): Consultants, Heads of Discipline and ICP coordinator.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Five ICP’s did not adequately identify the resource required to provide the care and treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific: ICP training is scheduled for the team in Mid January this will address this specific area of non compliance. Measurable: ICP’s will be audited quarterly to ensure that the ICP's now comply with the Regulation. Achievable/Realistic: Achievable. Time-bound: 31/03/2020. Post-Holder(s): Consultants, Heads of Discipline and ICP coordinator.</td>
</tr>
</tbody>
</table>

<p>| <strong>Preventative Action</strong> | Specific: ICP's will be audited quarterly to ensure that the ICP's now comply with the Regulation. Measurable: ICP’s will be audited quarterly to ensure that. Achievable/Realistic: Achievable. Time-bound: 31/03/2020. Post-Holder(s): ICP coordinator. |</p>
<table>
<thead>
<tr>
<th>Reason ID : 10000651</th>
<th>Three ICPs were not developed by the MDT.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Vacancies remain in Psychology and Occupational Therapy and there is minimal time for input from Speech and Language making these issues ongoing. Risk assessments have been completed, put on the Risk Register and submitted to the Senior Management Team to address these at their meeting January 2020.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Risk assessments have been completed, put on the Risk Register and submitted to the Senior Management Team to address these at their meeting January 2020.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000652</th>
<th>Two ICPs were not developed within 7 days of admission.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>ICP education training to be rolled out in Mid January 2020 to the Team. Memo issued by Consultant to all Teams admitting to the Maryborough Centre advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Any admissions to the ward will have their ICP’s completed at the next ICP meeting. The ICP meetings take place each Tuesday afternoon at present on the ward.</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Specific</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>NCHD's attend the approved centre first thing each morning to address any issues with the residents general and mental health, this was addressed during the inspection process. Ward Consultants to do education session with the NCHD's on the importance of referral to appropriate Medical Health services All six monthly will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020. This will also be addressed at the ICP review on the ward for each resident.</td>
<td>Attendance of the doctors is being recorded on the ward, Failure of NCHD's to attend the ward are being monitored by the NIMS system and this gets flagged at the Approved Governance meeting and the Laois Offaly Senior management meeting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Consultants to do education session with the NCHD's on the importance of referral to appropriate Medical Health services All six monthly will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors</td>
<td>Failure of NCHD's to attend the ward are being monitored by the NIMS system and this gets flagged at the Approved Governance meeting and the Laois Offaly Senior management meeting</td>
<td>Achievable</td>
<td>07/01/2020</td>
<td>Consultants , NCHD's and CNM's</td>
<td></td>
</tr>
</tbody>
</table>
weekly training meeting in January 2020. This will also be addressed at the ICP review on the ward for each resident.

<table>
<thead>
<tr>
<th>Reason ID : 10000643</th>
<th>The six-monthly assessments were incomplete, 19(1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Specific: All six monthly have been reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020. The six monthly assessments when due will be completed prior to their ICP so they can also be addressed at the ICP review on the ward for each resident. Measurable: Consultant and NCHD's to audit the six monthly's to ensure compliance with the regulation</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Specific: All six monthly will be reviewed by the Team doctors to ensure compliance and address any issues. The six monthly assessments will also be addressed at the ICP review on the ward for each resident. Measurable: NCHD's to audit the six monthly's to ensure compliance with the regulation</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Reason ID: 10000645**  
The number and skill of staff was not appropriate to the assessed needs of the residents, 26(2).

<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>All outstanding vacancies been identified and have been put on the Maryborough Approved centre risk register. These will then be issued to the Senior Management team at their next meeting in January 2020. The approved centres risk register is a standing agenda item an the 3 Monthly Laois Offaly Senior Management Team Meetings</td>
<td>Agended item on both the Maryborough Approved Governance Meeting and the Laois Offaly Senior Management Meeting</td>
<td>Achieved</td>
<td>07/01/2020</td>
<td>Senior Management Team and the Maryborough Approved Governance Committee</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A monthly Maryborough Approved Governance Committee (MAGC) has been established to oversee all Governance and regulatory requirements for the Maryborough Approved center. Membership is composed of All Heads of Discipline or their representative, the Hospital administrator, and the ADON, RANP and CNM’s from the ward. The Staffing issues are now a standing agenda item at all the meetings to ensure compliance with regulations and monitoring of the CAPA’s.</td>
<td>Agenda item on both the Maryborough Approved Governance Meeting and the Laois Offaly Senior Management Meeting</td>
<td>Achieved</td>
<td>07/01/2020</td>
<td>the Maryborough Approved Governance Committee and the Laois Offaly Senior Management Meeting</td>
<td></td>
</tr>
</tbody>
</table>
## Regulation 32: Risk Management Procedures

### Reason ID: 10000644

Not all clinical and health and safety risks identified by the approved centre, had been documented on the risk register, 32(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Risk register is now a standing agenda item on the Monthly Maryborough Approved Governance Committee meetings. All safety risks will be entered on the ward risk register. They will be forwarded to this committee for discussion and risks that cannot be managed on the ward will be referred onwards to the Senior Management Team for addition to the escalated Laois/Offaly Risk Register if necessary. See attached chart for the risk process.</td>
<td>Monthly Governance meeting</td>
<td>Achieved</td>
<td>07/01/2020</td>
<td>Maryborough Approved Governance Committee: Heads of Discipline, Hospital Administrator, Adon, RANP and CNM's from the ward</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A monthly Maryborough Approved Governance Committee (MAGC) has been established to oversee all Governance and regulatory requirements for the Maryborough Approved centre. Membership is composed of All Heads of Discipline or their representative, the Hospital administrator, and the ADON, RANP and CNM's from the ward. The Risk Register is now a standing agenda item at all meeting to ensure compliance with regulations and monitoring of the CAPA's.</td>
<td>Monitoring is at the MAGC on a monthly basis</td>
<td>Achieved</td>
<td>07/01/2020</td>
<td>Heads of Discipline, Hospital Administrator, Adon, RANP and CNM's from the ward</td>
</tr>
</tbody>
</table>
### Code of Practice on Admission, Transfer and Discharge to and from an approved centre

<table>
<thead>
<tr>
<th>Reason ID: 10000634</th>
<th>An admission assessment had not been fully completed, 15.1.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The NCHD's have readmitted all residents on the ward with the POLL initial admission assessment document (see attached) to ensure compliance of existing residents. All admissions going forward will be using the new proforma and each admission document will be audited by the NCHD following admission.</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Ward Consultants to do education session with the NCHD's on the admission process and the new forms for admission in the approved centre. All admissions out of normal hours (night and weekend) will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued to Consultants and all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020 | Audit of the documentation by responsible Consultant. | Achievable | 31/03/2020 | Consultants |

<p>| Reason ID: 10000635 | The assessment did not include details regarding past psychiatric history, family history, current and historic information, medical history or any other relevant information, 15.3. |</p>
<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>New admission proforma from Maryborough team has started. This will address these area's (see attached document). All admissions going forward will be using the new proforma and each admission document will be audited by the NCHD following admission.</td>
<td>Monthly audits of the admissions</td>
<td>Achievable</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Ward Consultants to ensure that an education session with the NCHD's on the admission process and the new forms for admission in the approved centre. All admissions out of normal hours (night and weekend) will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued to all Consultants and all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020</td>
<td>Audits of the admission process by CNM and Consultant</td>
<td>Achievable</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Reason ID: 10000636</td>
<td>It was not known from the documentation if the resident's family member/carer/advocate had been involved in the admission process with resident's consent, 18.3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AC0008 Maryborough Centre, St. Fintan's Hospital
Approved Centre Inspection Report 2019
Page 68 of 76
| Corrective Action | A new admission proforma has been developed and a tick box checking system had been included to ensure family/advocate involvement with consent is captured. | completed see attached documentation | Achieved 07/01/2020 | Consultant, CNM's and Advanced Nurse Practitioner |
| Preventative Action | A new admission proforma has been developed and a tick box checking system had been included to ensure family/advocate involvement with consent is captured. | Admission audits will ensure compliance | Achieved 07/01/2020 | Consultant, CNM's and Advanced Nurse Practitioner |

**Reason ID: 10000637**

The discharge plan did not include reference to early warning signs of relapse and risks, 34.2.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>A new discharge summary document has been introduced which references early warning signs and risks (see attached)</td>
<td>Memo to all NCHD's and Consultants (see Attached) Will be captured on the discharge audit and new discharge checklist (see attached)</td>
<td>Achieved 07/01/2020</td>
<td>Consultants and NCHD's</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>A new discharge checklist has been devised, Ward Consultants to do education session with the NCHD's on the discharge process and the new forms for discharge in the Maryborough Approved centre. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo</td>
<td>Discharge checklist and Audit of all Discharges by consultant and CNM's</td>
<td>Achievable 31/03/2020</td>
<td>Consultants</td>
</tr>
</tbody>
</table>
Reason ID: 10000638

<table>
<thead>
<tr>
<th>Reason ID: 10000638</th>
<th>A comprehensive discharge summary was not issued within 14 days, 38.3(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A new discharge checklist has been devised. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>A new discharge checklist has been devised. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020</td>
<td>Discharge audit on each discharge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>A new discharge checklist has been devised, Ward Consultants to do education session with the NCHD’s on the discharge process and the new forms for discharge in the Maryborough Approved centre. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>A new discharge checklist has been devised, Ward Consultants to do education session with the NCHD’s on the discharge process and the new forms for discharge in the Maryborough Approved centre. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020</td>
<td>Discharge audit on each discharge and the new discharge checklist.</td>
</tr>
</tbody>
</table>
discussed at the Doctors weekly training meeting in January 2020

**Reason ID : 10000639**

The discharge summary did not include details of prognosis, mental state on discharge, follow up arrangements, names and contact details of key people for follow-up or risk issues such as signs of relapse, 38.4.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>A new discharge checklist has been devised to ensure compliance. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020. Audits on all discharges will be completed going forward.</td>
<td>Checklist and Audit on all discharges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>A new discharge checklist has been devised, Ward Consultants to do education session with the NCHD's on the discharge process and the new forms for discharge in the Maryborough Approved centre. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all</td>
<td>Discharge Checklist and Audit will ensure compliance</td>
</tr>
</tbody>
</table>
Reason ID : 10000640

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Details relating to family member/carer/advocate involved in the discharge were not documented, 39.1.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>A new discharge checklist has been devised and this area of non compliance is addressed on the checklist. (see attached) All discharges will be reviewed by the Team doctors to ensure compliance and address any issues.</td>
<td>Audit of all discharges to be completed going forward</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>A new discharge checklist has been devised, Ward Consultants to do education session with the NCHD's on the discharge process and the new forms for discharge in the Maryborough Approved Centre. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Auditing of all discharges by Consultant and CNM's</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
Weekly training meeting in January 2020

Reason ID: 10000641

| Details relating to a timely follow up appointment were not documented, 41.1(c). |
|---|---|---|---|---|
| **Corrective Action** | A new discharge checklist has been devised. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. | Audits of all Discharges going forward | Achievable | 31/03/2020 | Ward Consultants, NCHD's and CNM's |
| **Preventative Action** | A new discharge checklist has been devised. Ward Consultants to do education session with the NCHD's on the discharge process and the new forms for discharge in the Maryborough Approved centre. All discharges will be reviewed by the Team doctors to ensure compliance and address any issues. Memo issued by Consultant to all Doctors advising of the areas of non compliance and to be discussed at the Doctors weekly training meeting in January 2020. | Audits of all Discharges going forward | Achievable | 31/03/2020 | Ward Consultant and CNM's |
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.