Avonmore & Glencree Units, Newcastle Hospital

ID Number: AC0053

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Avonmore & Glencree Units, Newcastle Hospital
Greystones
Co Wicklow

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

Most Recent Registration Date: 1 March 2017

Conditions Attached: None

Registered Proprietor: HSE

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

Inspection Team:
Mary Connellan, Lead Inspector
Noeleen Byrne
Carol Brennan-Forsyth
Marianne Griffiths

Inspection Date: 5 – 8 February 2019
Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 20 – 23 March 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Tuesday 20 August 2019

2019 COMPLIANCE RATINGS

<table>
<thead>
<tr>
<th>REGULATIONS</th>
<th>RULES AND PART 4 OF THE MENTAL HEALTH</th>
<th>CODES OF PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>23</td>
<td>1</td>
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<td>1</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

- Green: Compliant
- Red: Non-compliant
- Gray: Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

Inspector of Mental Health Services

In brief

The approved centre was located on the outskirts of Newtownmountkennedy, Co. Wicklow. It comprised of two wards in single storey style, with an activities centre located in the grounds. Glencree Ward, the acute admission unit had capacity for 26 residents. Five sector teams Psychiatry of Old Age and a Mental Health Intellectual Disability team had admitting rights to the approved centre. Avonmore Ward provided continuing care and a long stay facility, with capacity for 26 residents. It also provided assessment and treatment for residents aged over 65 years from the Psychiatry of Old Age team or any of the sector teams.

Compliance with regulations, rules and codes of practice had decreased from 77% in 2018 to 69% in this inspection (2019). Seven (64%) of these non-compliances were rated as high risk, including a breach of Part 4 of the Mental Health Act 2001. Ten individual areas of compliance with regulations were rated excellent.

Conditions to registration

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

Safety in the approved centre

There were a number of good safety practices in operation:

- Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Appropriate hand-washing areas were provided for catering services and the kitchen areas were clean.
- Individual risk assessments were completed prior to episodes of seclusion, physical restraint and at admission, at resident transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.
- Structural risks, including ligature points, were effectively mitigated.
- There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.
- The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

However:

- The food fridge in Avonmore unit was rarely colder than 4 degrees Celsius, and at the time of the inspection, the gauge showed that the fridge temperature was 8 degrees Celsius. This was an unsafe method of food storage.
- Rooms were centrally heated, but pipes and radiators were not guarded and were exposed. Works were due to begin in two weeks after this inspection time to rectify this.
- Not all health care staff were trained in the following: fire safety, Basic Life Support, The Professional Management of Violence and Aggression, (PMAV) and the Mental Health Act 2001.
- In one seclusion episode, there was no documentary evidence that the resident was assessed to include a risk assessment prior to seclusion taking place.

**Care and treatment of residents**

There were some areas of appropriate care and treatment provided for residents:

- An evidence-based nutrition assessment tool was used and nutritional and dietary needs were assessed where necessary, and addressed in the resident’s individual care plan. The needs of residents identified as having special nutritional requirements were reviewed by a dietitian and intake and output charts were maintained for residents, where appropriate.
- Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies and available for those residents who could attend. Music therapy, gardening, and yoga were run in the Kilmullen Enterprise Centre.
- Residents on antipsychotic medication received all necessary annual assessments and had access to smoking-cessation programmes and supports.
- There was evidence of good practice in admission, transfer and discharge of residents.

However:

- There was no occupational therapy input into therapeutic programmes. Social workers and psychologists did not deliver any group work but attended MDT meetings and met with residents as required on a one to one basis.
- Not all residents from the approved centre could attend the Kilmullen Enterprise Centre and so had no access to therapeutic programmes.
- The individual care plans (ICPs) of residents were of very poor quality and showed a lack of training.
  - In four ICPs inspected, there was no evidence that the ICPs were developed within seven days of admission, and no evidence to indicate that the full multi-disciplinary team were involved in the creation of the ICP.
  - Two of the ICPs inspected did not contain specific and appropriately defined goals for the residents; instead, words such as ‘remains irritable’ were written in the resident’s goals section.
  - Five ICPs did not adequately identify the interventions required to meet the goals identified.
  - Seven ICPs did not identify the resources required to provide the care and treatment identified.
  - Not all the residents interviewed knew about their respective individual care plan.

- While the clinical files inspected showed that residents had received a six-monthly general health assessment including a physical examination, the assessments had not been adequately completed.
Residents’ Body Mass Index, weight, and waist circumference was not checked and recorded in two cases. Dental health assessments were not documented for three residents.

- One resident had an unmet need for an occupational therapy seating assessment, as there was no access to this service.

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

Residents’ privacy, dignity and autonomy were respected in some areas:

- Appropriate and reasonable visiting times were publicly displayed in the approved centre.
- A separate visiting area was provided where residents could meet visitors in private.
- Residents consent was sought and documented prior to conducting a personal search. The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted and it was implemented with due regard to the resident’s dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched.
- End of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected and the privacy and dignity of residents were protected. Representatives, family, next-of-kin, and friends of the resident were involved, supported, and accommodated during end of life care.
- There were clear signs in prominent positions where CCTV cameras were located. A resident was monitored solely for the purpose of ensuring his/her health, safety, and welfare. The cameras were incapable of recording or storing a resident’s image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.
- Resident records were securely stored in a filing cabinet in the locked nurse’s office in both units.
- The approved centre was clean, hygienic, and free from offensive odours. It was adequately lit and ventilated throughout. The physical structure and overall approved centre environment were developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents.
- The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, and repair of assistive equipment.

However:

- Accommodation was mainly dormitory style with only one single room available.
- The approved centre did not provide suitable furnishings to support resident independence, dignity and comfort. In Avonmore unit, four armchairs in the residents sitting room were in a poor state of repair.
- None of the bedrooms in Avonmore or Glencree units had bedside lockers for residents in which to store their personal items, or for their own comfort.
- The seclusion room had been used as a bedroom regularly since the last inspection. It had been used for seven consecutive days as a bedroom and frequently as an alternative to a low stimulus room. Seclusion rooms are not suitable for use as bedrooms and such use is in contravention of the Rules Governing the Use of Seclusion and Mechanical Restraint.
During episodes of seclusion, there was no evidence, to indicate that the three residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint.

**Human Rights**

- In the case of one patient who had been detained in hospital for more than three months there was no evidence that the patient had provided consent for the continuing administration of medication or if there had been a capacity assessment done to show that he/she had capacity or not to consent to treatment. This was in contravention of Section 60 of the Mental Health Act 2001, and Article 3 of the UN Convention on the Rights of People with Disabilities.
- There was no documented evidence to indicate that mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need and no evidence to indicate that mechanical restraint was only used when less restrictive alternatives were not suitable. Clinical files which contained a contemporaneous record, did not detail the following:
  - That less restrictive alternatives were implemented without success.
  - The situation where mechanical restraint was being applied.
  - The duration of the restraint.

**Responsiveness to residents’ needs**

The approved centre was responsive to residents’ needs:

- The service had commenced a survey to better understand the needs and interests of the service users while they were residents in Newcastle Hospital.
- Residents were generally complimentary about the care and treatment, the facilities and the food.
- Residents had access to books, board games, jigsaws, TV, DVDs, and CDs on both units. The Kilmullan Enterprise Centre was located on-site and offered recreational activities to residents. Opportunities were provided for indoor and outdoor exercise and physical activity such as walking on the grounds, but this was dependent on staff availability.
- Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable, and there were facilities available to support residents’ religious practices. Residents had access to multi-faith chaplains, if required.
- Residents were provided with a variety of wholesome and nutritious food, and had at least two choices for meals. Residents commented that they would like more snack food such as fruit to be available during the day. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

**Governance of the approved centre**

There was good governance of the approved centre in most areas:
• Relevant staff had received training in the identification, assessment, and management of risk and in incident reporting and documentation. All staff interviewed were able to articulate the risk management processes, as set out in the policy.

• The risk register was 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.

• The person with responsibility for risk, was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

• Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

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

• Required audits were completed within specified time frames.

However:

• The number and skill mix of staffing was insufficient to meet resident needs. At the time of the inspection, there was no designated occupational therapist working in the approved centre, and there was no occupational therapist regularly visiting the approved centre to meet with residents or attend multi-disciplinary team meetings.

• Not all health care staff received mandatory training in fire safety, Basic Life Support, The Professional Management of Violence and Aggression, (PMAV) and the Mental Health Act 2001.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The service had commenced a survey to better understand the needs and interests of the service users while they were residents in Newcastle Hospital. Based on the Recovery Star as an outcome measure, the information collected was to help the service to work on continued improvement of the service and advice in relation to future service planning.

2. Two representatives from the local Wicklow mental health forum had joined the approved centres operational management meeting which was held monthly.

3. Following an analysis of risk management and incident review processes, all National Incident Management system (NIMs) reviews are completed by the respective Multi-Disciplinary Team (MDT) prior to dissemination to the Risk Advisor and Quality and Patient Safety Committee.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the outskirts of Newtownmountkennedy, Co. Wicklow. It was set on an expansive site of woodland and greenery affording picturesque landscape and views. It comprised of two wards in single storey style separated by a visiting area and mobile shop. There was an activities centre located in the grounds that was also part of the approved centre. The site included two administrative buildings, a HSE kitchen and a special school.

Glencree Ward, the acute admission unit had capacity for 26 residents. On the first day of the inspection, there were 16 residents, two of whom had been in the approved centre greater than six-months. Accommodation was mainly dormitory style with one single room available. Five sector teams had admitting rights to the approved centre encompassing Bray North, Co Wicklow to Gorey, Co Wexford. Psychiatry of Old Age (POA) and a Mental Health Intellectual Disability team had admitting privileges to the approved centre.

Avonmore Ward provided continuing care and a long stay facility. It also provided assessment and treatment for residents aged over 65 years from the POA team or any of the sector teams. While it had capacity for 26 residents only 20 of these beds were in operation at the time of inspection. On the first day of inspection there were 12 residents all of who had resided in the approved centre greater than six-months. Twenty-two residents had been admitted and discharged from Avonmore Ward since the previous inspection. Accommodation was available in both dormitory and single rooms.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>52</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>28</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Number of wards of court</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>Number of patients on Section 26 leave for more than 2 weeks</strong></td>
<td>0</td>
</tr>
</tbody>
</table>
3.2 Governance

Community Healthcare East Executive Management Team were responsible for the overall management and governance of Avonmore and Glencree Units, Newcastle Hospital. Incorporating Dublin South East and Wicklow there were three approved centres, which included Newcastle Hospital and community mental health services. Monthly minutes evidenced a broad agenda that included items pertinent to the approved centre.

Operational Management Meetings for the Wicklow services occurred monthly. A variety of issues pertinent to the approved centre and local mental health services such as finance, recruitment and retention of staff and service development were discussed. Representatives from the local mental health forum now sat on the committee. A separate Quality and Safety Committee met monthly to consider issues relating to risk management, policy development, and incident review. Copies of the minutes of both these committees were provided to the inspectors and these indicated an active governance process relating to the approved centre.

Meetings with heads of clinical disciplines outlined both specific and more general risks together with support and supervision processes. In particular, recruitment and retention of staff posed on-going problems. This applied particularly to the medical and nursing disciplines. The psychology team was fully staffed and operational. The lack of occupational therapy in the approved centre and available to the community teams was on the risk register.

The approved centre’s policies were reviewed and updated with input from both clinical and managerial staff in consultation, as appropriate, with other stakeholders. All operating policies required by the regulations had been reviewed within the last three years. There was an audit programme mainly completed by nursing staff. Medical and social work staff had completed audits relating to medication management and therapeutic services.

3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
<td>✓</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X High</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>✓</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X Low</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X Moderate</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001 - Consent to Treatment</td>
<td>✓</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X High</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
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</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:

- Regulation 4: Identification of Residents
- Regulation 7: Clothing
- Regulation 8: Residents’ Personal Property and Possessions
- Regulation 10: Religion
- Regulation 11: Visits
- Regulation 12: Communication
- Regulation 13: Searches
- Regulation 20: Provision of Information to Residents
- Regulation 25: Use of Closed Circuit Television
- Regulation 29: Operating Policies and Procedures
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>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>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

The inspection team met with eight residents. Residents were generally complimentary about the care and treatment, the facilities and the food. Not all the residents interviewed knew their respective individual care plan. The lack of bedside lockers was commented negatively and this was further identified as a concern by the IAN representative.

Four completed resident questionnaires were returned to the inspectors. All four indicated that the residents understood their care plan, and knew who their key worker was. All four indicated that they had space for privacy but only three felt their privacy and dignity were respected. Two of the four felt that there was not enough activities during the day. On a scale of 1-10, with 1 being poor and 10 being excellent, two residents rated 10 out of 10 for overall experience of care and treatment, one resident rated 9, and one resident rated 8.

The Irish Advocacy Network (IAN) representative visited the approved centre weekly. There was a notice naming the IAN contact and details. The inspector met with the IAN representative to discuss issues and positive aspects as reported by residents. It was reported that staff were friendly, helpful, and supportive; the expansive grounds and positive wellbeing effect; and overall the food was good. Areas for improvement suggested by residents to the advocate included the provision of bedside lockers; the availability of more therapeutic activities; and more recreational activities particularly at weekends and in the evenings. Some residents had reported to the advocate how difficult and upsetting the experience of ‘seclusion’ had been for them. It was further stated that not all residents had been debriefed after a seclusion episode.
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
- Assistant Director of Nursing x 2
- Clinical Director and Consultant Psychiatrist
- Clinical Nurse Manager 3
- Clinical Nurse Manager 1
- Consultant Psychiatrist
- General Manager
- Head of Service - Mental Health
- Nurse Practice Development Coordinator
- Mental Health Act Administrator
- Occupational Therapy Manager
- Principal Psychology Manager
- Principal Social Worker
- Quality and Patient Safety Advisor
- Social Work Team Leader

Apologies were received on behalf of the Area Lead for Mental Health Engagement.

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. As applicable, these have been reflected in the relevant sections of the report.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the identification of 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 approved centre used name, photograph, medical record number, and date of birth of each resident as identifiers. The preferred person-specific identifiers used were appropriate to the residents’ communication abilities, and were detailed within residents’ clinical files. The identifiers were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used to help staff in distinguishing between residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Irish Food Pyramid. Residents had at least two choices for meals. Meals were served three times daily. Residents commented that they would like more snack food such as fruit to be available during the day. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot and cold drinks were offered to residents regularly.

An evidence-based nutrition assessment tool was used. Weight charts were implemented, monitored, and acted upon for residents, where appropriate. Nutritional and dietary needs were assessed, where necessary, and addressed in the resident’s individual care plan. The needs of residents identified as having special nutritional requirements were reviewed by a dietitian and intake and output charts were maintained for residents, where appropriate.

The approved centre’s menus were not approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs. Instead, the menus were approved by the chef and catering staff.

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented and evidence of certification was available.

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

Evidence of Implementation: Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Appropriate hand-washing areas were provided for catering services. There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

There were proper facilities for the storage, preparation, cooking, and serving of food but not for the refrigeration of food. The fridge in Avonmore unit was rarely colder than 4 degrees, and at the time of the inspection, the gauge showed that the fridge temperature was 8 degrees Celsius.

The approved centre was non-compliant with this regulation because the fridge temperature was not cold enough for the safe refrigeration of food, with the temperature in Avonmore unit’s fridge of 8 degrees Celsius, 6(1)(b).
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy on residents’ clothing. 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. A record of residents wearing nightclothes during the day, as indicated by their ICP, was kept and monitored.

Evidence of Implementation: Residents changed out of nightclothes during daytime hours unless specified in their ICPs. Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised clothing.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant 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: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre’s policy.

Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions. Residents were encouraged to send valuables home if possible. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff and the resident or their representative.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in April 2017. The policy included the requirements of the Judgement Support Framework with the exception of the methods of communicating recreational activities and individual activities programmes with the residents.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. The resident information booklet given to residents, detailed accessible and user-friendly information on recreational activities, including the type and frequency of recreational activities. Residents had access to books, board games, jigsaws, TV, DVDs, and CDs on both units. The Kilmullan Enterprise Centre was located on-site and offered recreational activities to residents. Residents had to be referred to this facility to use it. Opportunities were provided for indoor and outdoor exercise and physical activity such as walking on the grounds, but this was dependent on staff availability. Documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file, as appropriate.

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

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

INSPECTION FINDINGS

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

Training and Education: 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’ rights to practice religion were facilitated within the approved centre insofar as was practicable, and there were facilities available to support residents’ religious practices. Residents had access to multi-faith chaplains, if required. They were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

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

INSPECTION FINDINGS

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

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

Monitoring: There were no residents with visitor restrictions in place at the time of the inspection. Analysis was completed to identify opportunities to improve visiting processes. This was documented.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private. There was a dedicated visitors’ room off the main foyer, and there was access to a visitor centre between Glencree and Avonmore units.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room and facilities were suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in April 2017. The policy 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 communication, as set out in the policy.

Monitoring: No residents had current had restrictions on their communication. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: There were no restrictions on residents’ communication at the time of the inspection. Residents could use mail, fax, and telephone if they wished. Residents did not have access to Wi-Fi including e-mail within the approved centre unless they used their own devices. The Kilmullan Enterprise Centre on-site had Wi-Fi access available to residents who were referred there.

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

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

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

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

**Monitoring:** A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had been completed to identify opportunities for improvement of search processes.

**Evidence Of Implementation:** The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file for one resident who was searched was inspected. Risk had been assessed prior to the search of the resident and their property. The resident’s consent was sought and documented. General written consent was sought for routine environmental searches.
The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

The search was implemented with due regard to the resident’s dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying, which was last reviewed in April 2017. The policy addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: End of life care provided to residents was not systematically reviewed to ensure section 2 of the regulation had been complied with. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: Three residents had died in expected circumstances since the last inspection. One clinical file was inspected in relation to care of the dying processes. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. This was documented in their individual care plan. Religious and cultural practices were respected. The privacy and dignity of residents were protected. The resident was provided with a single room within the approved centre. Representatives, family, next-of-kin, and friends of the resident were involved, supported, and accommodated during end of life care. All deaths of residents were reported to the Mental Health Commission within the required 48-hour timeframe.

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 staff training and education, and monitoring pillars.
Regulation 15: Individual Care Plan

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

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

INSPECTION FINDINGS

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

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: The ICPs of ten residents were inspected. Each ICP was a composite set of documents stored in the clinical file. Each resident was assessed at admission and an initial care plan was completed by the admitting clinician to address the immediate needs of the resident. A key worker was identified in all 10 ICPs inspected to ensure continuity in the implementation of residents’ ICPs.

All ICPs included a preliminary discharge plan. All ICPs were reviewed by the MDT in consultation with the resident at least every six months. There was evidence of resident involvement in all ICPs. As appropriate ICPs were drawn up with family and next of kin involvement. The ten ICPs inspected included an individual risk management plan. Residents had access to their ICPs and were kept informed of any changes. All residents were given a copy of their ICP including any reviews. Where a resident declined or refused a copy of their ICP, this was documented.

In four ICPs inspected, there was firstly no evidence that the ICPs were developed within seven days of admission. Two of the ICPs inspected did not contain specific and appropriately defined goals for the residents; and for one, words such as ‘remains irritable’ were written in the resident’s goals section. Five ICPs did not adequately identify the interventions required to meet the goals identified. Seven ICPs did not identify the resources required to provide the care and treatment identified.

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

   a) In four ICPs inspected, there was firstly no evidence that the ICPs were developed within seven days of admission.

   b) Two of the ICPs inspected did not contain specific and appropriately defined goals for the residents; instead, words such as ‘remains irritable’ were written in the resident’s goals section.
c) Five ICPs did not adequately identify the interventions required to meet the goals identified.

d) Seven ICPs did not identify the resources required to provide the care and treatment identified.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

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

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based and where provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies. This was away from the ward and available for those residents who could attend. Music therapy, gardening, and yoga were run in the Kilmullen Enterprise Centre (KEC), but there was no occupational therapy input into these programmes and not all residents had access to the KEC. A record was maintained of participants, engagement, and outcomes achieved in therapeutic services or programmes within each resident’s clinical file.

Therapeutic programmes and services were insufficient and did not meet the assessed needs of all the residents as documented in their individual care plans. Some therapies were provided within the Kilmullen Enterprise Centre but not all residents from the approved centre could attend it. While social work and psychology worked on an in-reach basis only within the approved centre, there was no designated social work, psychology, or occupational therapy staff for residents to access in the approved centre. One resident had an unmet need for an occupational therapy seating assessment. A resident had an identified need for a low stimulus environment. This was not available other than the seclusion room which was not an appropriate facility. Social work and psychology did not deliver any group work but attended MDT meetings and met with residents as required on a one to one basis.

A list of all therapeutic services and programmes provided in the approved centre was not available to residents. Where a resident required a therapeutic service or programme that was not provided internally, such as occupational therapy assessments, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location.
The approved centre was non-compliant with this regulation because of the following reasons:

a) The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16(1).

b) One resident had an unmet need for an occupational therapy seating assessment at the time of the inspection, 16(1).

c) One resident had an identified need for a low stimulus environment. This was not available other than the seclusion room which was not an appropriate facility, 16(1).
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 transfer policy was last reviewed in April 2017. The policy included the requirements of the Judgement Support Framework with the exception of the process for managing resident property during the transfer process.

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre to another healthcare facility was examined. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident’s care and treatment plan, including needs and risks, and the resident’s accompaniment requirements on transfer.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in April 2017. The policy included the requirements of the Judgement Support Framework with the exception of the staff training requirements in relation to basic life support.

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

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored. 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: Staff in the approved centre had an emergency resuscitation trolley, which was checked weekly. They had access at all times to an Automated External Defibrillator, which was also checked weekly. Five clinical files inspected showed that residents received appropriate general health care interventions in accordance with their documented identified needs in their ICPs. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs. Adequate arrangements were in place for residents to access general health services and be referred to other health services as required. Residents on antipsychotic medication received all necessary annual assessments.

Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. Residents had access to smoking-cessation programmes and supports.

Residents’ general health needs were monitored and assessed at least every six months. While the clinical files inspected showed that residents had received a six-monthly general health assessment including a physical examination, the assessments had not been adequately completed. Residents’ Body Mass Index, weight, and waist circumference was not checked and recorded in two cases. Dental health assessments were not documented for three residents.

NON-COMPLIANT
Quality Rating Requires Improvement
Risk Rating MODERATE
The approved centre was non-compliant with this regulation because the six-monthly general health assessment did not record Body Mass Index, waist circumference and dental health in all cases, 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 operational policy and procedures in relation to the provision of information to residents, which was last reviewed in April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents were provided with a service-user booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, and residents’ rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team (MDT). Residents were provided with relevant advocacy and voluntary agencies details, on a separate document.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident’s diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. The content of medication information sheets includes information on indications for use of all medications to be administered to
the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was rated 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 operational policy in relation to resident privacy, which was last reviewed in April 2017. The policy addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. This comprised of a walkabout which was conducted weekly to identify any privacy issues in both units. A tick list was completed and issues were addressed. Analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were called by their preferred name. The general behaviour of staff and the way in which staff interacted with residents was respectful. Staff were discreet when discussing the resident’s condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. Locks had an override function. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

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 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 is practicable and in accordance with best contemporary practice.

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


INSPECTION FINDINGS

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

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had not been completed to identify opportunities for improving the premises.

Evidence of Implementation: Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to the implementation for possible impact on current residents and staff. The Mental Health Commission was informed prior to the commencement of works. Remote or isolated areas of the approved centre were monitored. Back-up power was available in the approved centre.

The approved centre was clean, hygienic, and free from offensive odours. It was adequately lit and ventilated throughout. Hazards and ligatures had been minimised. The physical structure and overall approved centre environment were developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents.

Lighting in the communal rooms suited the needs of residents and staff for reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs. There was a cleaning schedule implemented. The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, and repair of assistive equipment. Records were maintained.
Resident bedrooms were appropriately sized to address the resident needs. There was a sufficient number of toilets and showers for residents in the approved centre. Rooms were centrally heated, but pipes and radiators were not guarded and were exposed. Works were due to begin in two weeks after this inspection time to rectify this. Heating could not be safely controlled in the resident’s own room; instead, heating was controlled centrally. The approved centre did not provide suitable furnishings to support resident independence and comfort. In Avonmore unit, four armchairs in the residents’ sitting room were in a poor state of repair. None of the bedrooms in Avonmore or Glencree units had bedside lockers for residents in which to store their personal items, or for their own comfort.

The approved centre was non-compliant with this regulation because the approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22(2).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in April 2017. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all nursing, pharmacy, and medical staff had signed the signature log to indicate that they had read and understood the policies. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

**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:** Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident’s MPAR. A record was kept when medication was refused by the resident.

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

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Medication fridges were kept locked. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.
Medications that were no longer required, which were past their expiry date, or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was 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 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 two written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in December 2017. The policies combined addressed all the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the health and safety 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: There was a clear written operational policy dated March 2017 in place in regard to the use of closed circuit television (CCTV). The policy included all of the requirements of the Judgement Support Framework, including details of the purpose and function of using CCTV for observing residents in the approved centre.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff could articulate the processes on the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images was checked regularly to ensure the equipment was operating appropriately. This was documented. Analysis was completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located. A resident was monitored solely for the purpose of ensuring his/her health, safety, and welfare. The Mental Health Commission had been informed about the approved centre’s use of CCTV. The cameras were incapable of recording or storing a resident’s image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: The implementation and effectiveness of the staff training plan were reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: The organisational chart in place identified the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment.

Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. The number and skill mix of staffing was insufficient to meet resident needs. At the time of the inspection, there was no designated occupational therapist working in the approved centre, and there was no occupational therapist regularly visiting the approved centre to meet with residents or attend multi-disciplinary team meetings. A written staffing plan was not available within the approved centre.

Staff were trained in Children First, manual handling, infection control and prevention, risk management and treatment, incident reporting, and the protection of children and vulnerable adults. Not all health care staff were trained in fire safety, Basic Life Support, Professional Management of Violence and Aggression, (PMAV) and the Mental Health Act 2001. This is outlined in the table below.
All staff training was documented and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glencree Unit</td>
<td>CNM3</td>
<td>0</td>
<td>1 (Shared)</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Avonmore</td>
<td>CNM3</td>
<td>0</td>
<td>1 (Shared)</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, or PMAV, 26(4).

b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

c) The numbers and skill mix of staff was not appropriate to the assessed needs of residents, the size and layout of the approved centre. There was no input from an occupational therapist into the ongoing care and treatment of the residents, 26(2).
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 two written policies and procedures in relation to the maintenance of records. The Maintenance of Records Policy was last reviewed in December 2017. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The way in which entries in residents’ records are made, corrected, and overwritten.
- General safety and security measures in relation to 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. Not all clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre. Residents’ records were accessible to authorised staff only, and only authorised staff made entries in them. All residents’ records were secure, up to date, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were stored in a filing cabinet in the secure nurse’s office in both units.

Resident records were reflective of the residents’ status and the care and treatment being provided. There were two appropriate resident identifiers recorded on all documentation. Resident records were developed and maintained in a good order, with no loose pages, and records were in a logical sequence. Each entry in residents’ records did not include the time using the 24-hour clock. Entries made by student nurses/clinical training staff were countersigned by a registered nurse/clinical supervisor. Where an error was made on a resident record, the correction of the error did not always include the date, time, and initials.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met did not meet all criteria of the Judgement Support Framework.
Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
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 up-to-date register of residents admitted. The register contained information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006 with the following exceptions:

- Date of birth was not recorded.
- Address was not recorded.
- Country of birth was not recorded.
- Diagnosis on admission or provisional diagnosis was not recorded.
- Diagnosis on discharge was not recorded.

The approved centre was non-compliant with this regulation because the register did not include all of the information specified in Schedule 1 to these Regulations, 28(2).
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

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

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

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

Evidence Of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff through a hard copy of each policy. The approved centre planned to move to an electronic policy format in 2019 with an electronic signature system.

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

The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Where generic policies were used, the approved centre had a written statement to this effect adopting the generic policy, which was reviewed at least every three years.

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

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in April 2017. The policy and procedures included all of the requirements of the <em>Judgement Support Framework</em>.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.</td>
</tr>
<tr>
<td><strong>Monitoring:</strong> Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.</td>
</tr>
<tr>
<td><strong>Evidence of Implementation:</strong> The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend their Mental Health Tribunal and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.</td>
</tr>
</tbody>
</table>

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 place in relation to the management of complaints. The policy was last reviewed in December 2017. The approved centre also used the HSE’s Your Service, Your Say complaints policy and process. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, and for the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were handled promptly, appropriately and sensitively.

One stage two complaint had taken place since the last inspection. The quality of the service, care and treatment of the resident was not adversely affected by reason of the complaint being made. Minor
complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint.

Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept separate from the resident’s individual care plan. The complainant’s satisfaction or dissatisfaction with the investigation findings was not documented because the complainant did not respond to the letter which was issued to them.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. All information in relation to complaints which were escalated to the nominated person were kept in a locked office.

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 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 procedures, which was last reviewed in April 2017. The policy addressed requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- The person responsible for the completion of six-monthly incident summary reports.
- Capacity risks relating to the number of residents in the approved centre.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk but they were not trained in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.
**Monitoring:** The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence Of Implementation:** The person with responsibility for risk, was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Individual risk assessments were completed prior to episodes of seclusion, physical restraint and at admission, at resident transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were effectively mitigated.

Corporate risks and health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre and were documented in a risk register. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

Clinical risks were not identified, assessed, treated, monitored, and recorded in the risk register.

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, staff training and education, and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

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

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

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually and it was last reviewed in April 2018. There was a separate written policy and procedures on the use of CCTV in the seclusion area. The policies included all of the relevant guidance criteria of this rule pursuant to Section 69 of the Mental Health Act 2001.

Training and Education: Not all staff involved in seclusion had signed to indicate that they had read and understood the policy. A record of attendance at training in seclusion was maintained and presented to the inspection team.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings, which did not endanger resident safety. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file. CCTV was evident in the seclusion area and clearly labelled. It was viewed only by designated personnel and the dignity of the resident was not compromised. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

The clinical files’ of three residents who had been in seclusion were inspected. In two episodes, seclusion was only implemented in the resident’s best interests, in rare and exceptional circumstances where the resident posed a serious harm to self or others. In the third episode, the use of the seclusion room was not in the best interest of the patient, but was used to manage other clinical demands. In this instance, not all uses of seclusion were clearly recorded in the clinical file or on the seclusion register. In one seclusion episode reviewed there was no documentary evidence that the resident had been informed of the reasons, duration, and circumstances leading to discontinuation of seclusion.

The seclusion room had been used as a bedroom regularly since the last inspection. It had been used for seven consecutive days as a bedroom and frequently as an alternative to a low stimulus room.

The approved centre was non-compliant with this rule for the following reasons:
a) There was no evidence in one episode inspected that the resident had been informed of the reasons, duration, and circumstances leading to discontinuation of seclusion, 3.6.

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

c) Not all uses of seclusion were clearly recorded in the resident’s clinical file, 9.1.

d) Not all uses of seclusion were clearly recorded on the seclusion register, 9.2.

e) Not all staff involved in seclusion had signed to indicate that they had read and understood the policy, 10.2 (b)
Section 69: The Use of Mechanical Restraint

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

INSPECTION FINDINGS

The clinical files of two residents who had been mechanically restrained were inspected. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist acting on his/her behalf.

Each clinical file contained a contemporaneous record that specified the following:
- That there was an enduring risk of harm to self or to others.
- The type of mechanical restraint.
- The duration of the order.
- The review date.

In both cases of mechanical restraint, there was no documented evidence to indicate that mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need. In both cases, there was no evidence to indicate that mechanical restraint was only used when less restrictive alternatives were not suitable.

Both clinical files which contained a contemporaneous record, did not detail the following:
- That less restrictive alternatives were implemented without success.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.

The approved centre was not compliant with this rule for the following reasons:

a) In both cases of mechanical restraint, there was no documented evidence to indicate that mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need, 21.1.
b) In both cases, there was no evidence to indicate that mechanical restraint was only used when less restrictive alternatives were not suitable, 21.2.
c) Both clinical files which contained a contemporaneous record, did not detail that following:
   - That less restrictive alternatives were implemented without success, 21.5 (b)
   - The situation where mechanical restraint was being applied, 21.5 (d)
   - The duration of the restraint, 21.5 (e).
9.0 Inspection Findings – Mental Health Act 2001

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

In relation to these two patient who were unable to consent to treatment, a Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been appropriately completed. All forms were completed within the appropriate timeframe and evidenced the following:

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

For one patient, who was in receipt of continuous medication for at least three months there was no documented evidence to indicate that the patient had the ability to understand the nature, purpose and likely effects of the treatment or that the patient was willing to consent to treatment. The consultant psychiatrist had not assessed the patient’s ability to consent to the treatment, or an assessment of the patient’s ability to understand the nature, purpose and likely effects of the treatment.

This was completed on one of the days of the inspection. The patient was assessed as being able to understand the nature, purpose and likely effects of the medication and was willing to consent to continue taking the medication. This was recorded in a written consent form which detailed the following:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of discussions with the patient, including
  – The nature and purpose of the medications.
  – The effects of the medications, including any risks and benefits.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because there was no documented evidence to indicate that one patient had the ability to understand the nature, purpose and likely effects of the treatment or that the patient was willing to consent to treatment.
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, dated April 2018. It addressed the provision of information to residents, details of who can initiate and who may implement physical restraint, and child protection processes where a child is physically restrained.

Training and Education: Not all staff involved in physical restraint had signed the signature sheet, indicating that they had read and understood the policy. A record of staff attendance at training on the use of physical restraint was maintained.

Monitoring: There was an annual report on the use of physical restraint in the approved centre.

Evidence of Implementation: Three clinical files were inspected in relation to the use of physical restraint. In all three cases, the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others, after other interventions had first been considered, and following a risk assessment.

Each episode was initiated by an appropriate staff member, and a designated staff member was the lead. The episodes of physical restraint were not prolonged beyond the period necessary. Gender sensitivity was demonstrated during each episode.

In all episodes, it was documented that the consultant psychiatrist was notified as soon as was practicable. In all episodes, a registered medical practitioner conducted a medical examination of the resident within three hours of the start of physical restraint.

In each case, next of kin were informed of the use of physical restraint. There was no evidence, however to indicate that the three residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint.

In all three episodes, the use of physical restraint was reviewed by the multi-disciplinary team (MDT) and documented in the clinical files within two working days.

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

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

b) There was no evidence to indicate that the three residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in January 2018, the transfer policy was last reviewed in October 2017, and the discharge process policy was last reviewed in October 2017. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident’s family member/carer/advocate were involved in the admission process, with the resident’s consent. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by a key-worker. A discharge plan was in place as part of the individual care plan (ICP). All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the MDT, and the resident’s family. A comprehensive pre-discharge assessment was completed; which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team (MDT) input into discharge planning. A preliminary discharge summary was sent to the general practitioner within three days. A comprehensive discharge summary was issued within 14 days, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

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

<table>
<thead>
<tr>
<th>Regulation 6: Food Safety</th>
<th>Reason ID: 10000005</th>
<th>The fridge temperature was not cold enough for the safe refrigeration of food, with the temperature in Avonmore unit's fridge of 8 degrees Celsius, 6 (1) (b).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td></td>
<td>Stand alone poly-</td>
<td>Visible unit along with temperature log</td>
</tr>
<tr>
<td></td>
<td>machine purchased</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for dispensing milk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>at Avonmore Ward.</td>
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<tr>
<td></td>
<td>Issues arising in</td>
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<tr>
<td></td>
<td>respect of</td>
<td></td>
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<tr>
<td></td>
<td>temperature control</td>
<td></td>
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<td></td>
<td>due to frequency of</td>
<td></td>
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<tr>
<td></td>
<td>accessing milk in</td>
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<td></td>
<td>fridge now</td>
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<tr>
<td></td>
<td>addressed.</td>
<td></td>
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<tr>
<td></td>
<td>Temperature</td>
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</tr>
<tr>
<td></td>
<td>monitoring in place.</td>
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</tbody>
</table>
| Preventative Action       | On-going monitoring | A food temperatures log sheet is maintained and monitored                                                                   | Achieved            | 28/05/2019 | Catering Manager,
|                           | of fridge           |                                                                                                                                 |
|                           | temperatures to     |                                                                                                                                 |
|                           | ensure food stored  |                                                                                                                                 |
|                           | at correct          |                                                                                                                                 |
|                           | temperature         |                                                                                                                                 |
### Regulation 15: Individual Care Plan

#### Reason ID: 10000008

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-compliances with ICP process were addressed and corrected. All ICP’s have been reviewed and updated with appropriate goals for the resident. This is documented in the individual ICP’s.</td>
<td>Individual care plans are audited on a quarterly basis</td>
<td>Achieved</td>
<td>03/04/2019</td>
<td>MDT/ Key Worker / PIC</td>
</tr>
</tbody>
</table>

#### Preventative Action

<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>To introduce a new ICP form in the approved centre. ICP training session for all relevant MDTs. Regular analysis to identify opportunities to improve the individual care planning process.</td>
<td>Quarterly Audit and weekly checklist</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>MDT/ Audit Group</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000009

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All ICP’s have been reviewed. The necessary care and treatment to meet the goals identified is documented in the individual ICP’s.</td>
<td>Quarterly Audit</td>
<td>Achieved</td>
<td>03/04/2019</td>
<td>MDT/ Key worker</td>
</tr>
</tbody>
</table>
### Preventative Action

| Preventative Action | To introduce a new ICP form in the approved centre. ICP Training session for all relevant MDTs. Regular analysis to identify opportunities to improve the individual care planning process. | Analysis / Review weekly checklist | Achievable | 31/07/2019 | MDT/ Audit Group |

### Corrective Action

| Corrective Action | Seven ICPs did not identify the resources required to provide the care and treatment identified. | All residents individual care plans currently identify the resources required to provide the care and treatment identified. | Quarterly Audit | Achieved | 03/04/2019 | MDT/ Key Worker / PIC |

### Preventative Action

| Preventative Action | To introduce a new ICP form in the approved centre. ICP Training session for all relevant MDTs. Regular analysis to identify opportunities to improve the individual care planning process. | Regular Analysis / Review Weekly Checklist | Achievable | 31/07/2019 | MDT/ Key Worker |

### Corrective Action

| Corrective Action | In four ICPs inspected, there was firstly no evidence that the ICPs were developed within seven days of admission. | Non-compliance with developing preliminary care plans were addressed and | Quarterly Audit | Achieved | 03/04/2019 | Admitting clinician / MDT/ Key Worker |
Each resident is initially assessed at admission. An initial care plan is completed by the admitting clinician to address the immediate needs of the resident. An individual care plan is developed by the MDT following a comprehensive assessment within seven days of admission.

| Preventative Action | On-going review of resident's ICP's on a weekly basis by MDT. This is documented. | Regular analysis to identify opportunities to improve the individual care planning process | Achievable | 31/07/2019 | MDT |
### Regulation 16: Therapeutic Services and Programmes

<table>
<thead>
<tr>
<th>Reason ID: 10000006</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16(1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access is provided to therapeutic services for residents on an individual basis. This is documented in the residents ICPs. HODs meeting to be held in relation to findings of MHC report regarding lack of therapeutic input and actions to be determined.</td>
<td>ICP audit / Meeting minutes</td>
<td>Achievable</td>
<td>31/10/2019</td>
<td>HODs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic needs analysis undertaken on admission and this need is incorporated into the residents Integrated Care Plan (ICP). A new leaflet to be developed for residents in relation to therapeutic services and programmes. A list of all therapeutic services and programmes to be developed and displayed within the approved centre.</td>
<td>Review Clinical File and information folder for resident. Visual programme.</td>
<td>Achievable</td>
<td>31/10/2019</td>
<td>Consultant / Key Worker / HODs</td>
</tr>
<tr>
<td>Reason ID : 10000007</td>
<td>One resident had an unmet need for an occupational therapy seating at the time of the inspection, 16 (1).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>This need has now been met. ICP audit / ongoing monitoring by Physiotherapist. Achieved 01/04/2019 Occupational Therapy and Physiotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Pathway identified for addressing seating needs assessment. Analysis Achievable 31/08/2019 Occupational Therapy and Physiotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000191</th>
<th>One resident had an identified need for a low stimulus environment. This was not available other than the seclusion room which was not an appropriate facility, 16 (1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The approved centre has identified an appropriate room to meet the resident's need for low stimulus environment. Visible Achievable 31/12/2019 HSE Estates, Senior Management and MDT</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>On-going monitoring of residents needs, as documented in the ICP. Regular analysis is completed to identify opportunities for improvement. This is documented. Audit and analysis Achievable 31/10/2019 MDT</td>
</tr>
</tbody>
</table>
### Regulation 19: General Health

**Reason ID : 10000012**

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>The six-monthly general health assessment did not record Body Mass Index, waist circumference and dental health in all cases, 19 (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>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. A new Physical Health Assessment Form will be introduced to meet the documentation requirements in relation to general health assessments.</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Review Clinical file / six-monthly general health assessment form</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Achievable</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>04/06/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Admitting clinician / registrar/ consultant/ Key worker</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Six monthly general examination checklists introduced within the approved centre. All clinical files will be reviewed bi-monthly for the completion of general health needs reviews.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>Analysis</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Achievable</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>03/06/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Key worker / PIC</td>
</tr>
</tbody>
</table>
**Regulation 22: Premises**

**Reason ID: 10000013**

The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22(2).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement armchairs for Avonmore Unit have now been ordered. Possible solutions to address the lack of bedside storage are currently being explored, in the context of available space and patient safety, with a view to resolving this matter as soon as possible.</td>
<td>Analysis</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>General Manager / PIC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Analysis is completed to identify opportunities to improve the premises.</td>
<td>Regular Analysis</td>
<td>Achievable</td>
<td>31/08/2019</td>
<td>General Manager / PIC</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID</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>1000014</td>
<td>The numbers and skill mix of staff was not appropriate to the assessed needs of residents, the size and layout of the approved centre. There was no input from an occupational therapist into the ongoing care and treatment of the residents, 26, (2).</td>
<td>Numbers and skill mix of staff is reviewed against the levels recorded in the approved centre's registration.</td>
<td>Barriers: Staff recruitment and retention. Efforts to recruit a Senior Occupational Therapist via agency were unsuccessful. Approval granted to advertise internally for temporary appointment. Process currently underway.</td>
<td>31/12/2019</td>
<td>Executive Management Team/HODs</td>
</tr>
</tbody>
</table>

#### Corrective Action
- There are on-going efforts to recruit sufficient number and skill mix of staff to meet residents identified needs. Approval granted to recruit a Senior Occupational Therapist dedicated to the Approved Centre.
- Numbers and skill mix of staff is reviewed against the levels recorded in the approved centre's registration.
- Analysis to identify opportunities to improve the processes for staffing is documented.
- Analysis
- Achievable
- 31/12/2019
- Executive Management Team/HODs

#### Preventative Action
- Workforce plan for Approved Centre to be developed to address skill mix, competencies, number and qualifications of staff. Analysis to identify opportunities to improve the processes for staffing is documented.
- Analysis
- Achievable
- 31/12/2019
- Executive Management Team/HODs

<table>
<thead>
<tr>
<th>Reason ID</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>1000082</td>
<td>Not all staff had up-to-date mandatory training in Basic Life Support, Fire Safety, or PMAV 26(4) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).</td>
<td>Not all staff had up-to-date mandatory training in Basic Life Support, Fire Safety, or PMAV 26(4) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Staff training log register /database in place. Training needs analysis completed and schedule for training identified and circulated.</td>
<td>Training need analysis is completed</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Heads of Discipline</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Senior management team will ensure that all HODs facilitate staff training for their areas of responsibility and maintain a training log for all MDT members.</td>
<td>Auditing via training log statistics</td>
<td>Barriers- Staff shortage to facilitate release of staff to attend training.</td>
<td>31/12/2019</td>
<td>SMT/HODs/MDT</td>
</tr>
</tbody>
</table>
Regulation 28: Register of Residents

<table>
<thead>
<tr>
<th>Reason ID : 10000017</th>
<th>The register did not include all of the information specified in Schedule 1 to these Regulations, 28(2).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specific</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>A new excel patient register introduced which contains all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Regular analysis to ensure that the register of residents contains up-to-date and accurate information.</td>
</tr>
</tbody>
</table>
## Code of Practice on the Use of Physical Restraint in Approved Centres

### Reason ID: 10000002

There was no evidence to indicate that the three residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8.

<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 staff resource folder will be developed and implemented to ensure compliance with Code of Practice on physical restraints. Following physical restraints, key worker will ensure that residents are afforded opportunity to discuss the episode with relevant MDT members and that this is documented in residents clinical notes.</td>
<td>Quarterly audit on Physical Restraint Process</td>
<td>Achievable</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Algorithm will be developed and implemented to ensure compliance with Code of Practice on physical restraints. Physical restraints and post MDT review stickers to be introduced within the approved centre, to improve the compliance with physical restraints process.</td>
<td>Regular analysis</td>
<td>Achievable</td>
<td>31/08/2019</td>
</tr>
</tbody>
</table>

### Reason ID: 10000003

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

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Policy dissemination session on physical restraint and code of practice will be held in July 2019. Implemented PPPG signature log register for staff who have read and understood policy and Code of Practice.</td>
<td>Review of the PPPG signature log register on quarterly basis</td>
<td>Achievable</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Review and monitor the PPPG signature sheet.</td>
<td>Analysis</td>
<td>Achievable</td>
<td>31/08/2019</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------</td>
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</tr>
</tbody>
</table>

## Rules Governing the Use of Mechanical Means of Bodily Restraint

### Reason ID: 10000029

Both clinical files which contained a contemporaneous record, did not detail that following:

- That less restrictive alternatives were implemented without success, 21.5 (b).
- The situation where mechanical restraint was being applied, 21.5 (d).
- The duration of the restraint, 21.5 (e).

<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>Resident clinical file reviewed and currently documentation specifies that less restrictive alternatives have been implemented, including indication and duration of mechanical restraint.</td>
<td>Audit</td>
<td>Achieved</td>
<td>30/05/2019</td>
<td>Consultant / Key Worker / PIC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop and implement Key Steps in Process of Mechanical Restraint for Immediate Threat of Serious Harm to Self or Others. Analysis completed to identify opportunities to improve the resident seclusion process. This is documented.</td>
<td>Visible / Analysis</td>
<td>Achievable</td>
<td>30/06/2019</td>
<td>CNM3 / PIC / Key worker</td>
<td></td>
</tr>
</tbody>
</table>

### Reason ID: 10000083

In both cases of mechanical restraint -There was no documented evidence to indicate that mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need, 21.1. -There was no evidence to indicate that mechanical restraint was only used when less restrictive alternatives were not suitable, 21.2.

<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>Resident clinical file reviewed and at present documentation includes residents clinical need for the use of mechanical means of</td>
<td>Review Clinical file</td>
<td>Achieved</td>
<td>30/05/2019</td>
<td>Consultant / Key worker / PIC</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Bodily restraint and alternatives intervention implemented.</td>
<td>Visible / Analysis</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>CNM3/ PIC</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------</td>
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</tr>
</tbody>
</table>

To develop and implement Key Steps in Process of Mechanical Restraint for Immediate Threat of Serious Harm to Self or Others. Analysis completed to identify opportunities to improve mechanical restraint process. This is documented.
### Rules Governing the Use of Seclusion

#### Reason ID: 10000018

<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>Policy dissemination session on use of Seclusion will be held within the approved centre in July 2019. Implemented PPPG signature log register for staff who have read and understood the policy.</td>
<td>Review of the PPPG signature log</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>HODs/ MDT</td>
</tr>
</tbody>
</table>

#### Corrective Action

- **Policy dissemination session on use of Seclusion** will be held within the approved centre in July 2019. Implemented PPPG signature log register for staff who have read and understood the policy.
- **Analysis of Policy dissemination process**

#### Preventative Action

- **Policy dissemination planner in place for 2019**

#### Reason ID: 10000019

<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>The seclusion room was used as a bedroom 8.4</td>
<td>Analysis of Policy dissemination process</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>CNM3</td>
</tr>
</tbody>
</table>

#### Corrective Action

- **Non-compliance addressed and corrected immediately. The seclusion facility is no longer used as a bedroom or as an alternative to a low stimulus room.**

#### Preventative Action

- **Seclusion facility where used, is strictly in accordance with the Rules Governing the Use of Seclusion**

#### Reason ID: 10000025

<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>There was no evidence in one episode inspected that the resident had been informed of the reasons, duration, and circumstances leading to discontinuation of seclusion, 3.6.</td>
<td>Regular Analysis</td>
<td>Achievable</td>
<td>30/06/2019</td>
<td>MDT</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>At present, in each episodes of seclusion, the patient is communicated of the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of seclusion. In the event that this information does not provided, a record explaining why it has not occurred, clearly documented in the patient's clinical file.</td>
<td>Review clinical File / Ask Patient</td>
<td>Achieved</td>
<td>26/06/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Develop and display algorithm on key Steps in Seclusion Process. Implement seclusion care bundle</td>
<td>Audit Seclusion Process</td>
<td>Achievable</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

Reason ID : 10000085

| Corrective Action | At present, the Person who initiates the Seclusion documented the details of seclusion process in the clinical file and clearly recorded on the seclusion register. | Review Clinical File and seclusion register. | Achieved | 26/06/2019 | Registered Medical Practitioners and/or Registered Nurses |
| Preventative Action | Introduction of seclusion care bundle, Each episode of seclusion is reviewed by members of the multi- | Review seclusion care bundle / check list | Achievable | 31/12/2019 | MDT |
disciplinary team, no later than 2 normal working days after the episode of seclusion.
## Part 4 of the Mental Health Act 2001: Consent to Treatment

**Reason ID : 10000004**

There was no documented evidence to indicate that one patient had the ability to understand the nature, purpose and likely effects of the treatment or that the patient was willing to consent to treatment.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-compliances were addressed and corrected immediately</td>
<td>Review Clinical File / Consent form</td>
<td>Achieved</td>
<td>06/02/2019</td>
<td>Consultant Psychiatrist</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>The Consultant Psychiatrist responsible for the care and treatment of the patient will document patient’s ability of understanding the nature, purpose and likely effects of the proposed treatment and willingness to consent to treatment. This will be evidenced by a capacity assessment and documented in patient clinical file.</td>
<td>Regular analysis</td>
<td>Achievable</td>
<td>31/08/2019</td>
<td>Consultant psychiatrist</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

- a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
- b) See every patient the propriety of whose detention he or she has reason to doubt.
- c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
- d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

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

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

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

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