O'Casey Rooms, Fairview Community Unit

ID Number: AC0083

2019 Approved Centre Inspection Report (Mental Health Act 2001)

O'Casey Rooms, Fairview Community Unit
Griffith Court
Philipsburgh Avenue
Dublin 3

Conditions Attached: Yes

Approved Centre Type:
- Acute Adult Mental Health Care
- Psychiatry of Later Life
- Mental Health Rehabilitation

Registered Proprietor: HSE

Most Recent Registration Date: 8 March 2017

Registered Proprietor Nominee:
Ms Anne Marie Donohue, General Manager Mental Health Services, CHO DNCC

Inspection Team:
Noeleen Byrne, Lead Inspector
Marianne Griffiths
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Inspection Date: 12 – 14 March 2019

Previous Inspection Date: 12 – 15 June 2018

Inspection Type: Unannounced Annual Inspection

Date of Publication: Thursday 11 July 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2019 COMPLIANCE RATINGS

REGULATIONS
- Compliant
- Non-compliant
- Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH
- Compliant
- Non-compliant

CODES OF PRACTICE
- Compliant
- Non-compliant
- Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

Dr Susan Finnerty

In brief

O’Casey Rooms was a 25-bed unit on the first floor of a community nursing unit owned by the Sisters of Charity, St. Vincent’s Hospital, Fairview. The approved centre was under the governance and management of North Dublin Mental Health Services (NDMHS) and had been renting this first-floor space since 2011 from the Sisters of Charity. Residents in O’Casey Rooms were under the care of either the Rehabilitation Team or the Mental Health Service of Older Persons/Psychiatry of Later Life Team. Most of the residents had been in residential mental health services for many years and as they aged, their care and treatment requirements were now significantly focused on physical, palliative and end of life care.

There had been a 9% decrease in compliance with regulations, rules and codes of practice since 2017, from 79% in 2017 to 70% in 2019. Four regulations were non-compliant for three consecutive years, including Regulation 15 Individual Care Plan. Five compliances with regulations were rated as excellent.

Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: The approved centre shall implement a plan to close O’Casey Rooms, Fairview Community Unit. The approved centre shall provide a progress update on the closure plan to the Mental Health Commission in a form and frequency prescribed by the Commission.

Condition 2: Effective 1st January 2018, the Mental Health Commission prohibits any direct admission or transfers of residents to the approved centre, with the exception of current residents that are transferred back to the approved centre following the receipt of care and treatment from an approved centre, hospital or other place.

Finding on this inspection: The approved centre was not in breach of Condition 1 and 2.

Safety in the approved centre

- Hazards were minimised in the premises and ligature points were minimised.

However:

- In five of ten individual care plans inspected, there was no documented risk management plan, although there were individual risk assessments.
There were a number of medication practices, which had the potential to lead to serious medication errors, and the medication policy was out of date.

Not all healthcare professionals were up-to-date with Children First, Basic Life Support (BLS), fire safety, Mental Health Act 2001 training, or Therapeutic Management of Violence and Aggression and Violence (TMVA) or Management of Actual or Potential Aggression (MAPA); however, there was a significant increase in the number of staff who had their training up-to-date in 2019.

Appropriate care and treatment of residents

- A key worker was identified for each resident.
- There was also an individual care plan (ICP) coordinator, who was a member of the multi-disciplinary team, and they ensured continuity in the implementation of residents’ ICPs.
- There was an impressive range of therapeutics activities and programmes for residents, including Sonas focusing on sensory stimulation, wellness and recovery (WRAP), reminiscence, mindfulness, relaxation, ‘Let’s Have Fun’, exercise, pamper, and an emotions and feelings group. These groups were run by trained therapists and were produced or co-produced by the occupational therapists, psychologists, social workers, and the activities nurse.
- The Compassion End of Life (CEOL) programme had been introduced to improve end of life care for residents and their families.

However:

- In two of ten ICPs reviewed, there was no evidence that the ICP was discussed and drawn up with the participation of the resident, their representative, family or next of kin or that it was not practicable. There was no evidence in two ICPs that the residents had access to the ICP, were informed of any changes, or were offered a copy of their ICP. Three ICPs were not reviewed by the multi-disciplinary team (MDT) in the previous six months.
- There was inadequate monitoring of physical health status of residents. Two residents did not have a general health assessment completed in the previous six months. In three completed general health assessments, Body Mass Index (BMI), weight and waist circumference were not recorded. Three residents on antipsychotic medication did not have an annual assessment of blood lipids, prolactin and an electrocardiogram (ECG).

Respect for residents’ privacy, dignity and autonomy

- Appropriate signage and sensory aids such as pictorial, written, braille, and photographic prompts were provided to support resident orientation needs.
- Each resident had a single bedroom which was appropriately sized to address the resident’s needs.
- The internal areas of the approved centre were clean, with the exception of the visitors’ kitchenette. This was cleaned when brought to the attention of the staff by the inspectors.
- There was a sufficient number of toilets and showers for residents in the approved centre and toilets were accessible and clearly marked.
However:

- Residents did not have access to personal space in the day room as the room was too small.
- The approved centre was very warm on the first day of the inspection. There was no thermostatic control of heating in the approved centre and staff had to contact maintenance to reduce the heat, which took a full day.
- There was limited outdoor space; the day room opened out onto a small courtyard or roof garden. This space was littered with cigarette butts and the smell of smoke was evident in the day room.
- The staff office was observed to be open and without any staff present on several occasions during the first two days of the inspection. Resident files were stored in the office on open shelves. Persons not authorised to access residents’ files were regularly in the adjacent corridor and, therefore, it would be possible to access resident files, leading to a breach in confidentiality.

**Human Rights**

There were no breaches of human rights evident in the approved centre at the time of inspection.

**Responsiveness to residents’ needs**

- Residents were provided with a variety of wholesome and nutritious food, and there was a choice of two meals at lunch and teatime. Meals were presented in an attractive form.
- There was a wide range of recreational activities appropriate to the resident group profile such as Bingo and informal music groups. The approved centre recently acquired a 70-inch interactive touch screen known as “Clever Touch”. It included an electronic whiteboard where word wheel and crosswords from the daily newspaper could be accessed by residents. Residents watched concerts on a digital music channel. Music quizzes were arranged on screen and the music through a Bluetooth device. “Armchair Travel” took place each week to a different destination. Other activities included pampering sessions, hair and beauty, prayers, knitting and reading. A summer garden party and afternoon tea on the lawn were held to enhance the Breath of Fresh Air Programme. This initiative was introduced to encourage families, visitors and residents to use the garden adjacent to the approved centre for walks and visits. At monthly meetings, residents discussed and suggested improvements to recreational activities. Otherwise, for some residents the outdoor space was only accessible with staff accompaniment. A garden project had commenced and staff and residents had chosen seeds and plants to enhance the garden and provide an activity for those who liked gardening.

However:

- Residents or families were not provided with relevant information regarding diagnosis or medication. There was information available regarding the approved centre in a booklet form. There was a robust complaints procedure in place.

**Governance of the approved centre**

- The O’Casey Rooms approved centre was part of the North Dublin Mental Health Service (NDMHS). NDMHS was part of Community Healthcare Organisation (CHO) 9 area, and responsibility for the management of O’Casey Rooms was designated to the senior management team of NDMHS.
• There was an organisational chart and clear governance structures and processes in place reflecting the NDMHS structures.

• Management were considering options to relocate O’Casey rooms to a more suitable premises as the current premises was not fit for purpose as an approved centre in the long term and the Mental Health Commission (MHC) had attached a condition prohibiting new admissions to the approved centre. Managing the approved centre, in the context of the conditions attached by the MHC to its registration, had presented a challenge to the service’s care pathways.

• Staffing shortages were acknowledged as an ongoing challenge; however, significant progress had been made to recruit staff. An emphasis had been placed on staff training and there was a higher number of staff trained demonstrating a commitment to training and education.

However:

• There was no formalised arrangement between O’Casey Rooms and St Vincent’s Hospital in terms of estate management or maintenance management. Instead, there was a reliance on goodwill to carry out repairs and routine maintenance.

• There was no system of performance appraisal for staff in the approved centre. Instead, it was reported that performance issues were addressed through clinical supervision.

• Planning for emergencies and evacuation was planned with other tenants who share the building. It was not clear that the management of O’Casey rooms could ensure a successful evacuation of residents, many of whom had physical disabilities, from the first floor without the use of lifts.

• There was an audit programme in place. Audit reports regularly showed 100% compliance and, therefore, did not include action plans for improvement. This was contrary to the fact that the MHC reported non-compliance year on year following annual inspections.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of the Compassion End of Life (CEOL) programme to improve end of life care for residents and their families.

2. A summer garden party and afternoon tea on the lawn were held to enhance the *Breath of fresh Air Programme*. This initiative was introduced to encourage families, visitors and residents to use the garden adjacent to the approved centre for walks and visits.

3. New Pamper group facilitated by Nursing and Hair and Beauty staff was established.

4. A reminiscence group was facilitated by occupational therapists.

5. A Wellness and recovery action plan (WRAP) group was introduced.

6. Introduction of Physical Health Interventions and Lifestyle Improvement Programme (Phillip) General Health Assessment form.

7. Workshops were developed to train staff on wound management “Pressure Ulcers to Zero”.

8. Workshops were prepared to train staff on depression and delirium guidelines.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre known as O’Casey Rooms was on the first floor of a community nursing unit owned by the Sisters of Charity, St. Vincent’s Hospital, Fairview. It was located in a residential area off Philipsburgh Avenue and at the rear of St. Vincent’s Hospital. O’Casey Rooms were under the governance and management of North Dublin Mental Health Services (NDMHS) and had been renting this first-floor space since 2011 from the Sisters of Charity.

Residents in O’Casey Rooms were under the care of either the Rehabilitation Team or the Mental Health Service of Older Persons/Psychiatry of Later Life Team. Most of the residents had been in residential mental health services for many years and as they aged, their care and treatment requirements were now significantly focused on physical, palliative and end of life care.

Access to the approved centre was by a stairs or lift. Accommodation comprised of 17 en suite bedrooms, two double bedrooms, and one four-bed dormitory. Each room or accommodation was personalised to the residents’ tastes and preference. It was apparent that for most of the residents the approved centre was their home. A small day room did not provide adequate space for the needs of the residents during the day. There was access to a small rooftop garden from the day room. Separately residents and their visitors’ could access a communal garden downstairs to the side of the building.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>25</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>20</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>20</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The O’Casey Rooms approved centre was part of the North Dublin Mental Health Service (NDMHS). NDMHS was part of Community Healthcare Organisation (CHO) 9 area, and responsibility for the management of O’Casey Rooms was designated to the senior management team of NDMHS. There was an organisational chart and clear governance structures and processes in place reflecting the NDMHS structures. A review of the minutes confirmed that these meetings addressed clinical governance, compliance and business issues. Quality and safety issues, escalated from the Quality and Safety committee, were discussed including serious
incidents, and appropriate actions taken. These structures were supported by Individual Care Planning, Quality & Patient Safety, Health & Safety, Drug and Therapeutic, and Emergency Planning Committees.

The Mental Health Commission’s Governance questionnaire had been completed by the approved centre’s:

- Area Director of Nursing
- Executive Clinical Director
- Clinical Director
- Principal Psychology Manager
- Occupational Therapy Manager
- Principal Social Worker

The inspection team met with or spoke to members of the senior management team as appropriate. Management were looking at options to relocate O’Casey rooms to a more suitable premises as the current premises was not fit for purpose as an approved centre in the long term and, as such, the Mental Health Commission (MHC) attached a condition prohibiting new admissions to the approved centre. Managing the approved centre, in the context of the conditions attached by the Mental Health Commission to its registration, had presented a challenge to the service’s care pathways. There was no formalised arrangement between O’Casey Rooms and St Vincent’s in terms of estate management or maintenance management. Instead, there was a reliance on goodwill to carry out repairs and routine maintenance.

There was no system of performance appraisal for staff in the approved centre. Instead, it was reported that performance issues were addressed through clinical supervision. Staffing shortages were acknowledged as an ongoing challenge however, significant progress had been made to recruit staff. An emphasis had been placed on staff training and there was higher numbers of staff trained demonstrating a commitment to training and education.

Planning for emergencies and evacuation was planned with other tenants who share the building. It was not clear that the management of O’Casey rooms could ensure a successful evacuation of residents, many of whom have physical disabilities from the first floor without the use of lifts.

There was a comprehensive audit programme in place. Audit reports regularly showed 100% compliance and therefore did not include action plans for improvement. This was contrary to the fact that the MHC reported non-compliance year on year following annual inspections.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>As the approved centre did not use physical restraint, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted and given an opportunity to give 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 six residents. Residents were complimentary about the care and treatment, the facilities, the food and in particular the staff. Most residents had single bedrooms and they were very comfortable. There were good comments about the therapies offered and the recreational activities held. One resident said they would like more to do at the weekends and another said they were happy living there.

No service user questionnaires were completed.
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:

- Acting Clinical Director
- Registered Proprietor
- Area Director of Nursing
- Occupational Therapy Manager
- Consultant Psychiatrist x 2
- Acting Assistant Director of Nursing
- Senior Psychologist
- Social Worker
- Clinical Nurse Manager 1
- Clinical Nurse Manager 3
- Staff Nurse in charge

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. Management confirmed that they planned to turn the four-bed dormitory into a new day room and move the therapies room to the current day room.
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.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre had a written policy in relation to the identification of residents, which was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> 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 identifying residents, as set out in the policy.</td>
</tr>
<tr>
<td><strong>Monitoring:</strong> 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.</td>
</tr>
<tr>
<td><strong>Evidence of Implementation:</strong> There were a minimum of two person-specific resident identifiers, appropriate to the resident group profile and individual residents’ needs. The preferred identifiers used for each resident were detailed within residents’ clinical files. Name and date of birth were used for administering medication. In addition, a photo of the residents was maintained on the medication trolley. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or a similar name.</td>
</tr>
</tbody>
</table>

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillars.
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Menus were reviewed by an external dietician. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. There was a choice of two meals at lunch and teatime. Meals were presented in an attractive form. Hot drinks were provided to residents with all meals and on request by staff. Cold drinks were readily available to residents.

There was a water dispenser in the dining room, which provided residents with a safe supply of fresh drinking water. A choice of hot meals was provided daily. An evidence-based nutrition screening tool, the Malnutrition Universal Screening Tool was used as applicable. Weight charts were maintained as appropriate. Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietician as required. Intake and output charts were maintained for residents as required.

There was no evidence that residents, their representatives, family, or next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindication with medication.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2018. The policy addressed requirements of the Judgement Support Framework, with the following exceptions of the processes and procedures for

- Food preparation, handling, storage, distribution and disposal controls
- Adhering to the relevant food safety legislative requirements
- The management of catering and food safety equipment

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food 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 not 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: The kitchen had an appropriate hand washing area. Staff had access to appropriate Personal Protective Equipment. Food was not prepared in the approved centre; only a cook-chill process was operated. Main meals were provided by St Joseph’s Hospital catering services. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned. Residents were provided with adequate supplies of appropriate cutlery and crockery.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 7: Clothing

The registered proprietor shall ensure that:
(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

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

Training and Education: Relevant staff had not signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented.

Evidence of Implementation: Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Some spare nightclothes were kept on the unit. Clothes could be purchased in nearby shops if necessary. Residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and pillar.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Personal property logs were monitored in the approved centre. An audit has been completed and had been completed to analyse the processes relating to residents’ personal property and possessions.

Evidence of Implementation: On admission, staff in the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre’s policy. The property checklist was kept separately to the resident’s ICP and was available to the resident. Residents were supported to manage their own property.

A system was in place to safeguard residents’ possessions. When a resident had a sum of money for safeguarding it was lodged in the accounts office. The clinical nurse manager or assistant director of nursing ensured that residents could access this money as required.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillars.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in August 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Bingo took place twice a week, as well as informal music groups. The approved centre recently acquired a 70-inch interactive touch screen known as “Clever Touch”. This interactive touch screen operated like a giant tablet device. It included an electronic whiteboard where word wheel and crosswords from the daily newspaper could be accessed by residents. Residents watched concerts on a digital music channel. Music quizzes were arranged on screen and the music through a Bluetooth device. “Armchair Travel” took place each week to a different destination. Other activities included pampering sessions, hair and beauty, prayers, knitting and reading. Residents went on trips at weekends. This was staff dependant. There were signs and visual displays appropriate to individual resident needs. At monthly meetings, residents discussed and suggested improvements to recreational activities. Staff assessed resident recreational needs according to the resident profile and previous attendance. A downstairs garden could be accessed and residents were brought for walks and outings. A Breath of Fresh Air project was in place to encourage family and friends to bring residents to the garden as appropriate. Otherwise, for some residents the outdoor space was only accessible with staff accompaniment. A garden project had commenced and staff and residents had chosen seeds and plants to enhance the garden and provide an activity for those who liked gardening.

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in Jan 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for identifying the residents' religious beliefs.

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

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

**Evidence of Implementation:** Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Prayers were said regularly in the approved centre. Mass was held weekly within the approved centre for residents who were unable to go out. Where staff resources allowed, residents were facilitated in attending local religious services of their choice. Residents were free to partake in or abstain from religious practice based on personal preference. At the time of inspection, no resident had any specific religious requirements in relation to care provision.

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

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Visiting times were displayed throughout the approved centre and were included in the resident information booklet. The approved centre was open to visitors with the exception of meal times. The approved centre had a number of visiting rooms together with a seating area in the foyer, external to the unit. Visits could also occur in resident bedrooms. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety. Requirements for visiting children were documented in the information booklet and on notices within the approved. The visiting rooms and additional visiting areas 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 May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents could use mail, fax, telephone, and internet if they wished, unless otherwise risk assessed with due regard to their well-being, safety, and health. At the time of the inspection, no resident was assessed as being at risk in relation to their communications, and therefore no resident communication was being examined by the clinical director or a designated senior staff member.

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

COMPLIANT

Quality Rating: Excellent
Regulation 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 May 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: As no searches had been conducted since the last inspection, monitoring was not applicable.

Evidence of Implementation: As no searches had been conducted since the last inspection, the approved centre was not inspected against the evidence of implementation pillar for this regulation.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in March 2018.

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

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

Evidence of Implementation: Since the last inspection three residents died. The clinical file relating to one resident was reviewed. The resident was nursed in a single room when nearing end of life. Discussions and consent regarding advance directives and associated documentation were evidenced in the clinical file. The approved centre had access to palliative care provision. The clinical file indicated that good practices were maintained in pain management, pastoral care, privacy and family support. All deaths of residents were notified to the Mental Health Commission within the required 48-hour timeframe.

The Compassion End of Life (CEOL) programme had been introduced to improve end of life care for residents and their families. This programme provided a framework, to embed a continuous improvement approach to end of life care that enhanced compassion and increases confidence among staff to provide end of life care in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
**Regulation 15: Individual Care Plan**

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in October 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** ICPs were maintained in a distinct folder within the clinical file. There were two different templates used, the Psychiatry of Older Age (POA) used a newer version. The reasons for non-compliance came largely from the review of the ICPs updated by the rehabilitation and recovery team. Ten ICPs were inspected and all documented the residents’ assessed needs with appropriate goals. The ICPs also identified the resources required to provide the care and treatment identified.

A key worker was identified for each resident and this was always a nurse. There was also an ICP coordinator, who was a member of the MDT team and together they ensured continuity in the implementation of residents’ ICPs.

In two of ten ICPs reviewed, there was no evidence that the ICP was discussed and drawn up with the participation of the resident, their representative, family or next of kin or that it was not practicable. In one of ten ICPs, the care and treatment did not reflect the interventions as outlined in the progress notes in the clinical file. In five of ten ICPs, there was no documented risk management plan. Three of ten ICPs were not reviewed by the MDT in the previous six months. There was no evidence in two of ten ICPs that the resident had access to the ICP, were informed of any changes or were offered a copy of their ICP.

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

- a) Two of ten ICPs reviewed did not document that the ICP was drawn up with the participation of the resident so far as practicable.
- b) One of ten ICPs did not reflect the care and treatment as outlined in the progress notes in the clinical file.
- c) Three of ten ICPs were not reviewed by the MDT at least every six months.
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 January 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Therapeutic services and programmes provided by the approved centre were extensive, evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents.

Therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. The Pool Activity Level (PAL) instrument, that standardises assessments and outcome measures, was used to profile residents with dementia. This was updated every three months and informs the ICP. Therapeutic groups included; Sonas focussing on sensory stimulation, wellness and recovery (WRAP), reminiscence, mindfulness, relaxation, ‘Let’s Have Fun’, exercise, pamper, and an emotions and feelings group. These groups were run by trained therapists and were produced or co-produced by the occupational therapists, psychologists, social workers, and the activities nurse.

Adequate and appropriate resources and facilities were not available to provide the therapeutic services and programmes. While there were dedicated staff to facilitate activities, and there were dedicated rooms for the delivery of therapeutic activities, the actual space used for this purpose was too small. One to one therapeutic sessions were arranged to compensate for the lack of space.

Generally, therapeutic services and programmes needed were provided internally. A record was maintained of participation, engagement, and outcomes achieved in therapeutic programmes, within residents’ clinical files. An occupational therapist was engaged in assessing residents for individual equipment, including support chairs and slings.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in January 2016. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A log of transfers was maintained, however there was only one transfer. This record had been reviewed to ensure all relevant information was provided to the receiving facility.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre to a general hospital as an emergency was examined. The resident was accompanied by a nurse on the transfer. Verbal communication was given to the receiving facility and this included the reasons for transfer and the residents care and treatment plan. A written copy of the medication prescription and administration record (MPAR) was provided including needs and risks.

As assessment of the resident’s physical condition was completed prior to the transfer, including a risk assessment relating to the transfer and the resident’s needs. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in May 2018. The medical emergencies policy was last reviewed in January 2017. The policies and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan (ICP).

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

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED) at all times. There was an emergency trolley; however, documentation reviewed showed that the emergency trolley had not been checked for 3 months rather than weekly as required.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents were encouraged to partake in appropriate national screening programmes. Residents had access to smoking cessation programmes and supports.

The clinical files of five residents were reviewed. Residents’ received appropriate general health care interventions in line with their ICPs. However, two of the five residents did not have a general health assessment completed in the previous six months. Of the three completed general health assessments body mass index (BMI), weight and waist circumference were not recorded. Three of five residents on antipsychotic medication did not have an annual assessment of blood lipids, prolactin and an electrocardiogram (ECG).

The approved centre was non-compliant with this regulation for the following reasons:
a) Two of five residents did not have a general health assessment completed in the previous six months, 19(1)(b).

b) The general health assessments of three residents did not record BMI, weight and waist circumference, 19(1)(b).

c) Three of five residents on antipsychotic medication did not have an annual assessment of blood lipids, prolactin and an electrocardiogram (ECG), 19(1)(b).
Regulation 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of information to residents. The policy was last reviewed in January 2017. The policy addressed requirements of the Judgement Support Framework, with the exceptions of the process for managing the provision of information to resident representatives, family and next-of-kin, as appropriate.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. Not 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 not monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: The information booklet for the approved centre contained the following: housekeeping arrangements, including arrangements for personal property and complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies; and residents’ rights. Residents had access to interpretation and translation services as required.

Residents were not provided with written and verbal information on diagnosis. No up to date written medication information sheets were available. A folder on the unit contained information from 2009 and information sheets had not been renewed.

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

a) Residents or families were not provided with relevant information regarding diagnosis, 20 (1)(c).
b) Residents or families were not provided with relevant information on the effects of medication, 20 (1)(e).
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in October 2016. The policy addressed requirements of the Judgement Support Framework, with the exceptions of the approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

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

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Staff were respectful of residents. Staff were appropriately dressed. Resident issues were only discussed in private and out of the hearing range of other residents. All residents were observed to be dressed in clean and appropriate personal clothing. Shared rooms had adequate bed screening between beds to ensure and safeguard resident’s privacy and dignity. The approved centre was located on the first floor and was not overlooked by surrounding properties.

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

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.
(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.
(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.
(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.
(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

INSPECTION FINDINGS

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

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

Monitoring: The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had not been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. Heating was centrally controlled and it could not be controlled in the resident’s own room. Appropriate signage and sensory aids such as pictorial, written, braille, and photographic prompts were provided to support resident orientation needs. Resident bedrooms were appropriately sized to address the resident needs. The approved centre provided assisted devices and equipment such as mobile hoists and ceiling hoists to address resident needs. Current national infection control guidelines were followed. There were two lifts inside the front door and these brought residents and visitors to the main entrance into O’Casey Rooms.

Hazards were minimised. Ligature points were minimised and due to the resident group profile and conditions, they were considered to be of low risk. The internal areas of the approved centre were clean, with the exception of the visitor’s kitchenette. This was cleaned when brought to the attention of the staff. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Back-up power was available and remote and isolated areas of the approved centre was monitored.
There was a sufficient number of toilets and showers for residents in the approved centre and toilets were accessible and clearly marked. Toilets were located close to the dining room and day room. Wheelchair accessible toilet facilities were identified for use by visitors. The approved centre had a dedicated sluice room. There was a cleaning schedule and a dedicated room for cleaning equipment. There was a dedicated laundry.

Maintenance requested were sent to St Vincent’s Fairview but there was no formalised arrangement to carry out repairs. There was no programme of routine maintenance. There was a reliance on goodwill from the St Vincent’s Fairview maintenance staff. Urgent repairs were carried out in a timely manner.

Residents did not have access to personal space in the day room as the room was too small. The approved centre was very warm on the first day of the inspection. There was no thermostatic control of heating in the approved centre and staff had to contact maintenance to reduce the heat. It took a day to reduce the temperature. There was limited outdoor space, the day room opened out onto a small courtyard or roof garden. This space was littered with cigarette butts and the smell of smoke was evident in the day room.

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

a) The courtyard and the visitors’ kitchenette were not clean, 22(1)(a).
b) There was no programme of routine maintenance in the approved centre, 22(1)(c).
c) The outdoor garden was not easily accessible and the small size of the dining room and day room indicated that the overall environment was not developed with due regard to the specific needs of the residents, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in January 2014. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for self-administration of medication.
- The process for medication reconciliation.

Training and Education: All nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

Evidence of Implementation: Ten Medication, Prescription and Administration Records (MPARs) were reviewed. All entries in the MPARs were written in black indelible ink. The MPARs had a maximum capacity of eight weeks before a re-write was required. This was documented in the clinical file. All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber, and any advice provided by the resident’s pharmacist regarding the appropriate use of the product. One of 10 MPARS had the prescription altered rather than have it rewritten. Micrograms was abbreviated rather than written in full in two of ten MPARS. A log of the temperature of the refrigerator was not recorded daily. There were gaps in the administration of medication record in two of ten MPARS. There was no discontinuation date for medications in two of ten MPARs. Some details were not legible in one of ten MPARS. Two of ten MPARS did not record the direction to crush the medication.

The expiration date of the medication was checked prior to administration. Expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. Schedule 2 controlled drugs were checked by two staff members against the delivery form and details were entered in the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book. Following administration, the details were entered in the controlled drug book and signed by both staff members.
Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. The medication storage area was observed to be cluttered and disorganised. Food and drink was not stored in areas used for the storage of medication. Medication was kept in a locked trolley in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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

a) Two of ten MPARS did not record the administration of medication, 23(1).
b) Two of ten MPARS did not record the discontinuation date of a medication, 23(1).
c) One MPAR had details that were illegible, 23(1).
d) Two of ten MPARS did not document the direction to crush medication, 23(1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in January 2016. It also had an associated safety statement, dated February 2019. The policies and the safety statement included all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the 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 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in May 2018. The policy addressed requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.

The policy did not address the following:

- The ongoing the frequency of training needed to provide safe and effective care and treatment in accordance to best contemporary practice.
- The required qualifications of training personnel.

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

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

Evidence of Implementation: There was an organisational chart that identified the leadership and management structure, line of authority and accountability of the approved centre’s staff. There was a planned and actual staff rota. The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times.
Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment. There was no written staffing plan but there was defined processes to manage skills mix, competencies, number, and qualification of staff.

An annual staff training plan had been completed that identified required training and skills development in line with the assessed needs of the resident group profile. Not all healthcare professionals were up-to-date with Children First, Basic Life Support (BLS), fire safety, Mental Health Act 2001 training, or Therapeutic Management of Violence and Aggression (TMVA) or Management of Actual or Potential Aggression (MAPA). This was being actively managed and improvements noted year on year and there was a significant increase in the number of staff who had their training up-to-date. Medical staff occupational therapists, social workers and psychologists had achieved 100% in most of the training as per the chart below.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (28)</td>
<td>21</td>
<td>75%</td>
<td>20</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Consultant Psychiatrist ( )</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Medical (3)</td>
<td>3</td>
<td>100%</td>
<td>3</td>
<td>100%</td>
<td>3</td>
</tr>
<tr>
<td>Occupational Therapist (4)</td>
<td>4</td>
<td>100%</td>
<td>4</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Social Worker (2)</td>
<td>2</td>
<td>100%</td>
<td>1</td>
<td>50%</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist (1)</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
</tbody>
</table>

Percentage of staff trained

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

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

a) Not all staff had up-to-date training in Basic Life Support, Fire Safety, Therapeutic Management of Violence and Aggression (TMVA) and Children’s First, 26(4).

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>O’Casey Rooms</td>
<td>CNM3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM1 Activities area</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.2 Rehab</td>
<td>0.2 Older persons</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.2 Rehab</td>
<td>0.2 Older persons</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in June 2018. The policy addressed the requirements of the Judgement Support Framework, including the following:

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

The policy did not address the process for making a retrospective entry in the residents’ records.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: Residents’ records were up to date, and in good order. Resident records were reflective of the residents’ status at the time of inspection and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were written legibly in black indelible ink and were readable when photocopied. Only authorised staff made entries in the residents’ records. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.
The staff office was observed to be open and without any staff present on several occasions during the first two days of the inspection. Resident files were stored in the office on open shelves. Persons not authorised to access residents files were regularly in the adjacent corridor, and therefore it would be possible to access resident files. This was rectified on the last day of the inspection.

The approved centre was non-compliant with this regulation because residents' files were not kept in a safe and secure place, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents which was not up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record discharge and re-admission dates when resident were transferred to another facility. The diagnosis on discharge was also not recorded.

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

a) Discharge and admission dates were not recorded, 28(1).

b) Diagnosis on discharge was not recorded, 28(1).
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 January 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 operating policies and procedures required by the regulations were all reviewed at least every three years with the exception of Regulation 18: Transfer of Residents and Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

Where generic policies were used, the approved centre had a written statement adopting the generic policy, which was reviewed at least every three years. Any generic policies used were appropriate to the approved centre and the resident group profile.

The format of policies and procedures was not fully standardised. Policies did not include the individual names of approvers, reviewers and the total number of pages.

The approved centre was non-compliant with this regulation because the written operational policies for Regulation 18: Transfer of Residents and Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines were not reviewed at least every three years.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints. The policy was last reviewed in April 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had been completed. An audit was documented and only one complaint was received and it had been acted upon and the complaint closed. There was no requirement to escalate to senior management to consider. Complaints data was analysed.

Evidence of Implementation: The nominated person responsible for dealing with complaints was based within the unit and was the Clinical Nurse Manager 2. The complaints officer was offsite but was clearly identified with contact details. The approved centre’s management of complaints was well publicised and accessible to residents and their representatives. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged. The registered proprietor also ensured access, insofar as practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

There was one minor complaint and this was documented. It had been addressed locally and was resolved.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in May 2018 and a safety statement dated February 2019. The policies addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The North Dublin Mental Health Service had an organisational risk register that was reviewed at least quarterly. The approved centre had no risk register; instead, they had a folder of relevant risk assessments. 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. Clinical, health and safety, and corporate risks were identified, assessed, treated, reported, monitored and documented in the risk register. Individual risk assessments were completed prior to and during mechanical restraint, at admission to identify individual risk factors, at resident transfer, at resident discharge, and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

There was evidence that the conditions attached to the Mental Health Commission registration were recorded on the corporate risk register. The risk management procedures actively reduced identified risks to the lowest practicable level of risk in relation to falls prevention. Environmental risks assessments were reviewed regularly and issues that could not be managed in the approved centre were escalated to the organisational risk register.

There was an emergency/evacuation plan in place which specified the required response by approved centre staff to possible emergencies. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission on an anonymised basis.

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two conditions to registration attached. The certificate was displayed prominently in the hall.

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 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 three residents who had been mechanically restrained was inspected. Mechanical restraint was only practiced when the residents posed an enduring risk of harm to themselves or to others. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the residents or the duty consultant psychiatrist acting on their behalf.

The clinical files contained a contemporaneous record that specified the following:

- That less restrictive alternatives were implemented without success.
- That there was an enduring risk of harm to self or to others.
- The type of mechanical restraint.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The approved centre was compliant with this rule.
Part 4 of The Mental Health Act 2001 Consent to Treatment was not applicable to this approved centre. Please see Section 4.3 Areas that were not applicable on this inspection for details.
10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
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 policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in November 2016. The transfer policy was last reviewed in January 2016, and the discharge policy was last reviewed in January 2014. The policies combined included all of the policy-related criteria of this code of practice.

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

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

Evidence of Implementation:

Admission: Admission is not applicable as there is a condition on the approved centre prohibiting any direct admissions.

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

Discharge: The clinical file of a resident, who had been discharged to a nursing home, evidenced a discharge plan with an estimated date of discharge, documented communication with the relevant nursing home and a follow up plan with reference to early warning signs of relapse and risks. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the nursing home.

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

**Regulation 15: Individual Care Plan**

<table>
<thead>
<tr>
<th>New Reason</th>
<th>Two of ten ICP's reviewed did not document that the ICP was drawn up with the participation of the resident so far as practicable.</th>
</tr>
</thead>
</table>

<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>Review ICPs to identify the omissions which occurred and rectify same</td>
<td>ICP Checklist and Monthly Audit</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>ICP to be fully completed in order to identify if Resident were present</td>
<td>ICP training to be available to MDT members. ICP Checklist to be completed monthly</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Reason</th>
<th>One of ten ICP's did not reflect the care and treatment as outlined in the progress notes in the clinical file.</th>
</tr>
</thead>
</table>

<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>Review ICPs to identify the omissions which occurred and progress notes to reflect ICPs</td>
<td>ICP Checklist Monthly Audit</td>
<td>Achievable &amp; Realistic</td>
<td>30/09/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>ICP to be fully completed and reflect progress notes</td>
<td>ICP training to be completed by MDT members. ICP Checklist Monthly Audit</td>
<td>Achievable &amp; Realistic</td>
<td>30/09/2019</td>
</tr>
<tr>
<td>New Reason</td>
<td>Three of ten ICPs were not reviewed by the MDT at least every six months.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Review ICPs to identify the omissions occurred and rectify same.</td>
<td>ICP Checklist Monthly Audit</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>ICP to be completed every 6 months</td>
<td>ICP Monthly Audit</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
</tr>
</tbody>
</table>
### Regulation 19: General Health

**New Reason**  
Two of five residents did not have a general health assessment completed in the previous six months, 19(1)(b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Identify residents who did not receive a general health assessment and rectify same</td>
<td>General health assessment completed General health assessment checklist completed</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
</tr>
</tbody>
</table>

**Preventative Action**  
Ensure all general health assessment are completed - 6 monthly  
Monthly Audits  
Achievable & Realistic  
30/06/2019  
Consultant Psychiatrist

**New Reason**  
The general health assessments of three residents did not record BMI, weight and waist circumference, 19(1)(b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Identify the residents who did have BMI, weight and waist circumference recorded and rectify same</td>
<td>Complete BMI, weight and waist circumference Record in residents file</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
</tr>
</tbody>
</table>

**Preventative Action**  
Ensure all relevant information for general health assessments are completed  
Monthly Audits On going  
Achievable & Realistic  
30/06/2019  
Consultant Psychiatrist

**New Reason**  
Three of five residents on antipsychotic medication did not have an annual assessment of blood lipids, prolactin and an electrocardiogram (ECG), 19(1)(b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
</table>
| **Corrective Action** | Identify the residents who are  
Complete blood lipids, prolactin and | Achievable & Realistic | 30/09/2019 | Consultant Psychiatrist |
<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Ensure all relevant assessments for general health are completed for residents</th>
<th>Monthly Audits Ongoing</th>
<th>Achievable &amp; Realistic</th>
<th>30/09/2019</th>
<th>Consultant Psychiatrist</th>
</tr>
</thead>
</table>

On antipsychotic medication who did not have an annual assessment of blood lipids, prolactin and ECG and rectify same.

ECG Record in residents file.
<table>
<thead>
<tr>
<th>New Reason</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>All residents &amp; families will be provided with relevant information regarding diagnosis and effects of medication</td>
<td>Quarterly audits Provision of information to residents Reg. 20</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
<td>Consultant Psychiatrist</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>All residents &amp; families will be provided with relevant information regarding diagnosis and effects of medication. Information leaflets on the use of medication is available in all bedrooms.</td>
<td>Quarterly Audits - Reg. 20</td>
<td>Achievable &amp; Realistic</td>
<td>30/06/2019</td>
<td>Consultant Psychiatrist</td>
</tr>
<tr>
<td>New Reason</td>
<td>The courtyard and the visitors' kitchenette were not clean, 22(1)(a).</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Routine programme has been developed and submitted to St. Vincents Hospital Fairview (SVHF) technical services. Routine maintenance programme to be updated as requested. Achievable &amp; Realistic 30/06/2019 CNM2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Schedule of maintenance to be monitored for completion Maintenance updates to be provided to ADON in O’Casey Rooms On going 30/09/2019 CNM2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Reason</th>
<th>There was no programme of routine maintenance in the approved centre, 22(1) c).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Routine programme has been developed and submitted to St. Vincents Hospital Fairview (SVHF) technical services. Routine maintenance programme to be updated as requested. Achievable &amp; Realistic 30/06/2019 CNM2</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Schedule of maintenance to be monitored for completion Maintenance updates to be provided to ADON in O’Casey Rooms On going 30/09/2019 CNM2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Reason</th>
<th>The outdoor garden was not easily accessible and the small size of the dining room and day room indicated that the overall environment was not developed with due regard to the specific needs of the residents, 22(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Business Case submitted to Head of Service Mental Minutes/Actions from Working Group To Be Confirmed This is ongoing, Head of Service and 30/09/2019 Head of Service MH</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Action</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Health for alternative accommodation to be sourced by HSE Estates, following actions from O’Casey Working Group</td>
<td>Estates are currently in discussions.</td>
</tr>
<tr>
<td>Reconfiguration of vacant 4 bedded area into a sitting room</td>
<td>Awaiting approval to commence work from St. Vincents Hospital Fairview</td>
</tr>
</tbody>
</table>
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

#### New Reason

Two of ten MPARS did not record the administration of medication, 23(1). Two of ten MPARS did not record the discontinuation date of a medication, 23(1). One MPAR had details that were illegible, 23(1). Two of ten MPARS did not document the direction to crush medication, 23(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training to all nursing and medical staff on the recording of administration of medication, discontinuation of medication and legible handwriting documentation on the direction to crush medication</td>
<td>MPAR audits (MPAR updated every 8 weeks Nurse Metrics)</td>
<td>Achievable &amp; Realistic</td>
<td>30/09/2019</td>
<td>Consultant Psychiatrist CNM3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training to all nursing and medical staff on the recording of administration of medication, discontinuation of medication and legible handwriting documentation on the direction to crush medication</td>
<td>MPAR audits (MPAR updated every 8 weeks Nurse Metrics)</td>
<td>Achievable &amp; Realistic</td>
<td>30/09/2019</td>
<td>Consultant Psychiatrist CNM3</td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

#### New Reason

Not all staff had up-to-date training in Basic Life Support, Fire Safety, Therapeutic Management of Violence and Aggression (TMVA) and Children's First, 26(4). Not all the staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All relevant staff to be identified and assigned training dates as soon as practicable</td>
<td>Training needs analysis updated and a focused training plan to identify training deficits</td>
<td>Achievable &amp; Realistic</td>
<td>31/12/2019</td>
<td>Heads of Discipline ADON</td>
</tr>
</tbody>
</table>

<p>| Preventative Action                    | Staff training database to be maintained Liaise with Training Providers   | Monthly training audits                                                   | Achievable &amp; Realistic | 31/12/2019 | Heads of Disciplines ADON MDT      |</p>
<table>
<thead>
<tr>
<th>New Reason</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All MDT staff are advised to ensure that the staff room door is locked on regress</td>
<td>Staff instucted on locking central staff room daily, all daily MDT meetings, safety pause meetings and daily handover sheet</td>
<td>Achievable &amp; Realistic</td>
<td>30/09/2019</td>
<td>MDT</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Induct all staff on records management and GDPR related to storage of residents file</td>
<td>Audit signature Records Management GDPR Policy</td>
<td>Achievable &amp; Realistic</td>
<td>31/12/2019</td>
<td>MDT</td>
</tr>
</tbody>
</table>
### Regulation 28: Register of Residents

<table>
<thead>
<tr>
<th>New Reason</th>
<th>Discharge and admission dates were not recorded, 28(1). Diagnosis on discharge was not recorded, 28(1).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specific</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Discharge and admission dates have been recorded for all residents Diagnosis on discharge have been recorded for all residents</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>To ensure admission and discharge dates are recorded for each resident To ensure diagnosis are recorded on discharge for residents.</td>
</tr>
<tr>
<td>New Reason</td>
<td>Specific</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>The written operational policies for Regulation 18 (Transfer of Residents) and Regulation 23 (Ordering, Prescribing, Storing &amp; Administration of Medicines) are currently being reviewed. Will be completed August 2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The written operational policies for Regulation 18 (Transfer of Residents) and Regulation 23 (Ordering, Prescribing, Storing &amp; Administration of Medicines) will be reviewed within the 3 year time frame.</td>
</tr>
</tbody>
</table>

**Regulation 29: Operating Policies and Procedures**

The written operational policies for Regulation 18: Transfer of Residents and Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines were not reviewed at least every three years.
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.