Owenacurra Centre

ID Number: AC0102

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Owenacurra Centre
Midleton
Co. Cork

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

Most Recent Registration Date: 9 December 2016

Conditions Attached: None

Registered Proprietor: HSE

Registered Proprietor Nominee: Kevin Morrison, General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
Susan O’Neill, Lead Inspector
Marianne Griffiths
Sarah Moynihan

Inspection Date: 30 April – 03 May 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 20 – 23 November 2018

Date of Publication: Monday 14 October 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2019 COMPLIANCE RATINGS

- **REGULATIONS**: 3 out of 6 compliant
- **RULES AND PART 4 OF THE MENTAL HEALTH**: 22 out of 25 compliant
- **CODES OF PRACTICE**: 1 compliant

Compliant | Non-compliant | Not applicable
--- | --- | ---
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

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

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

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

Owenacurra Centre was located in the town of Midleton, which facilitated community integration and social inclusion for residents. The approved centre was registered to provide a service for psychiatry of later life, continuing mental health care and mental health rehabilitation. The service catered for up to 24 residents and, at the time of the inspection, 21 residents were in the approved centre. The majority of residents required continuing care; however, three residents were admitted to avail of short stay rehabilitation services and one resident required a period of respite.

The approved centre was a single storey building with a large internal courtyard. There were 16 single bedrooms and 4 twin bedrooms, the latter with adjoining toilet facilities. A day centre service, accessible to all residents, was located within the premises. This service was also used by non-residents from the local community.

While compliance with regulations, rules and codes of practice has increased over the last three years (70% in 2017, 90% in 2018, and 79% in 2019), there has been some disimprovement since 2018.

Compliance with three regulations was rated as excellent.

Conditions to registration

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

Safety in the approved centre

- There were regular audits of food safety and kitchen areas were clean with adequate storage and refrigeration.
- There had been good progress in the mandatory training of staff.
- Ligature points had not been minimised to the lowest practicable level; however, based on risk assessment these were mitigated by the approved centre.

However:

- Medication management procedures were not consistently safe. The medication trolley did not remain locked at all times when stored within the clinical room. Medication due for return to the pharmacy was observed as being stored in an open box within the clinical room. In three cases,
medication administration records had not been signed to indicate that medications had been administered.

**Appropriate care and treatment of residents**

- Each resident had a multi-disciplinary individual care plan which outlined needs, goals, interventions and required resources. Residents had input to their care plans, which were reviewed regularly.
- Six-monthly general health assessments in the approved centre documented the following: physical examination; personal and family history; Body Mass Index; weight and waist circumference; blood pressure; smoking status; nutritional status, including diet and physical activity and sedentary lifestyle; medication review; and dental health. For residents on applicable antipsychotic medication, there was an annual assessment of the following: glucose regulation (fasting glucose/HbA1c), blood lipids, Electro-Cardiogram, and prolactin.

However:

- The services and programmes provided by the approved centre did not meet the assessed needs of all residents as the occupational therapy service was accessed via the local community team on a referral basis only. At the time of the inspection, the approved centre only had access to approximately five hours of occupational therapy time per week. Unmet needs were clearly documented in separate occupational therapy screening assessments for residents.

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

- Residents could meet their visitors in private and visiting times were flexible.
- Phone calls could be made in private and the residents received their mail unopened by staff.
- All bathroom, shower, toilet, and single bedroom locks had an override function. Bed screening curtains were in situ within shared bedrooms ensuring that residents’ privacy was not compromised. Net curtains were in place in bedrooms that were overlooked by a public area. Noticeboards did not display resident names or other identifiable information.
- Since the last inspection, the premises had undergone significant renovations, resulting in a good state of repair and decoration both internally and externally.
- The approved centre was clean, hygienic, and free from offensive odours.

However:

- The female residents’ corridor, which contained six female bedrooms, also had three staff offices.
- The day centre activity room was located just beyond this area, and outpatients and day hospital attendees accessed this corridor on a regular basis.
- There were only two showers available for resident use at the time of inspection. This was insufficient for the number of residents (21) within the approved centre.
Responsiveness to residents’ needs

- There were two activity nurses who provided activities in the approved centre on weekdays. The groups were attended by both community clients and inpatients. Residents had access to television, DVDs, music, books, art materials and a movie club. They also had access to a minibus to go on outings both on weekdays and weekends. Facilitators attended the approved centre weekly to run groups such as music and art and crafts. Cork Educational Training had a contract with the approved centre in relation to funding educational programmes. Walking and gardening groups were available for residents.
- At mealtimes, there was a good choice of food which was attractively presented.
- Information about the approved centre was provided in a booklet and there was also information about residents’ diagnoses and medication.
- There was a satisfactory complaints procedure in place.

Governance of the approved centre

- The approved centre was under the governance of the Cork Mental Health Management Team and within the overall governance of Cork Kerry Community Healthcare. At a local level, the approved centre held business meetings every six weeks and these were attended by all heads of discipline. Standing agenda items focused on development of the rehabilitation service, regulatory compliance issues, and local operational issues.
- There were defined risk management processes throughout the approved centre. A local risk register was maintained and this was reviewed on a quarterly basis at the business meeting at Owenacurra Centre. Audits of the local risk register were also undertaken regularly. Where actions to manage risks were identified, the risk register did not always record timeframes for the completion of these actions. Therefore, it was difficult to assess progress toward action completion.
- All heads of discipline reported undertaking a regular process of supervision with staff. Staff performance appraisals were not undertaken except within the discipline of psychology.
- The majority of staff had undertaken all required mandatory training. Training needs were monitored on a regular basis and there was a firm commitment to ensuring all staff were fully trained. There was no formal in-service training programme within the approved centre; however, informal training sessions did occur occasionally.
- A comprehensive programme of cyclical audit was undertaken, mostly by the nursing team. Due to the limited availability of other multi-disciplinary team members, and consequently, their need to prioritise clinical duties, multi-disciplinary participation in the audit process was minimal.
- At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. Residents also had access to advocacy services if required; advocacy contact details were displayed within the approved centre.
However:

- Access to some mental health disciplines was limited. At the time of the inspection, the approved centre only had access to 0.1 whole time equivalent (WTE) of occupational therapy per week. This was documented as one of the highest rated risks within the local risk register. In the context of the growing occupational therapy needs of the resident population and the ongoing development of the rehabilitation facet of the service, this was insufficient to meet the needs of residents. In 2017, a business case for a full time occupational therapist (OT) post dedicated to the Owenacurra Centre was submitted to the Mental Health Division; however, at the time of inspection, the service was still awaiting a response.
The following quality initiatives were identified on this inspection:

1. Establishment of a smoke free campus committee for the purpose of promoting a smoke free environment.

2. Delivery of training by the Mental Health and Intellectual Disability Service on the topic of personalised communication booklets (Communication Passports).

3. Introduction of the new service wide six monthly physical examination booklet.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Owenacurra Centre was located in the town of Midleton. The approved centre was registered to provide a service for psychiatry of later life, continuing mental health care and mental health rehabilitation. The service catered for up to 24 residents which was a reduction from the original registration number of 29. At the time of the inspection, 21 residents were admitted to the approved centre. The majority of residents required continuing care; however, three residents were admitted to avail of short stay rehabilitation services and one resident required a period of respite. Admissions to the approved centre were from the Midleton and Youghal catchment area.

The approved centre was a single story building with a large internal courtyard. There were 16 single bedrooms and 4 twin bedrooms, the latter with adjoining toilet facilities. A day centre service, accessible to all residents, was located within the premises. This service was also used by non-residents from the local community.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>24</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>21</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</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 approved centre was under the governance of the Cork Mental Health Management Team and within the overall governance of Cork Kerry Community Healthcare. At a regional level, the Cork management team met on a monthly basis. Standing agenda items pertained to quality and patient safety, finance, and provision of services, and regulatory compliance issues. At a local level, the approved centre held business meetings every six weeks and these were attended by all heads of discipline. Standing agenda items focused on development of the rehabilitation service, regulatory compliance issues, and local operational issues.

Within the approved centre, the multi-disciplinary team was comprised of all the core mental health disciplines; however, access to some disciplines was limited. At the time of the inspection, the approved centre only had access to 0.1 whole time equivalent (WTE) of occupational therapy per week. This limitation was reported as a key operational risk by multiple staff members and was also documented as one of the highest rated risks within the local risk register. In the context of the growing occupational therapy needs of
the resident population and the ongoing development of the rehabilitation facet of the service, this was insufficient to meet the needs of residents. In 2017, a business case for a full time occupational therapist (OT) post dedicated to the Owenacurra Centre was submitted to the Mental Health Division; however, at the time of inspection, the service was still awaiting a response.

There were defined risk management processes throughout the approved centre. A local risk register was maintained and this was reviewed on a quarterly basis at the business meeting at Owenacurra Centre. Audits of the local risk register were also undertaken regularly. Where actions to manage risks were identified, the risk register did not always record timeframes for the completion of these actions. Therefore, it was difficult to assess progress toward action completion.

All heads of discipline reported undertaking a regular process of supervision with staff. Staff performance appraisals were not undertaken except within the discipline of psychology. The majority of staff had undertaken all required mandatory training. Training needs were monitored on a regular basis and there was a firm commitment to ensuring all staff were fully trained. There was no formal in-service training programme within the approved centre; however, informal training sessions did occur occasionally. A comprehensive programme of cyclical audit was undertaken mostly by the nursing team. According to HSE best practice guidelines, the process of audit should be undertaken by the multi-disciplinary team where possible. However, due to the limited availability of other multi-disciplinary team members, and consequently, their need to prioritise clinical duties, multidisciplinary participation in the audit process was minimal.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. Residents also had access to advocacy services if required; advocacy contact details were displayed within the approved centre. At an area level, the Area Lead for Mental Health Engagement attended the monthly Cork Management Team meetings.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing and Administration of Medicines</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>High</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</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>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As no resident had been mechanically restrained since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>As no resident in the approved centre had been physically restrained since the last inspection, 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>
The Inspector gives emphasis to the importance of hearing the service users’ experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

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

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

The inspection team met with two residents. Both residents were complimentary of the staff and service provision. Both engaged with the activities programme which was varied. The food was described as excellent. Both attended their individual care planning meetings and were familiar with members of the multi-disciplinary team. One resident expressed a desire to speak with the doctor more frequently.

One resident questionnaire was completed. Overall, comments were positive and there were no specific issues raised.
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:

- General Manager
- Executive Clinical Director
- Clinical Director
- Assistant Director of Nursing
- Principal Social Worker
- Consultant Psychiatrist
- Senior Occupational Therapist
- Area Administrator

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. These were included in the relevant section of the report.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The identifiers used were person specific, and did not include the room or the physical location of the resident. Two appropriate resident identifiers were used when administering medication, medical investigations and also to provide additional healthcare services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The approved centre demonstrated the appropriate use of identifiers and alerts for residents with the same or similar name. In addition, the identifiers used were appropriate to the residents’ communication abilities.

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

1. The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.
2. The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident’s individual care plan.

INSPECTION FINDINGS

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

Monitoring: A systematic review of menu plans had not been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents in the approved centre had at least two choices of meals per day. Hot and cold drinks were offered regularly to residents. There was a source of safe, fresh drinking water made available to residents at all times in easily accessible locations throughout the approved centre. In addition, hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was not utilized in the approved centre. At the time of inspection, there was no process whereby residents, their representatives, family, and next of kin could be educated about residents’ diets, specifically in relation to any contraindications with psychotropic medication. The needs of residents identified as having special nutritional requirements were not regularly reviewed by a dietitian.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring 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 December 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 food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

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

Evidence of Implementation: There was evidence of suitable and sufficient catering equipment in the approved centre. 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. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection of food. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in December 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 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 supported to keep and use personal clothing. Residents were observed to be dressed in clean clothes throughout the inspection. Residents’ clothing was laundered on-site. Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans (ICPs). Residents had an adequate supply of their own clothing kept within their bedrooms.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in December 2016. The policy included all of the requirements of the Judgement Support Framework, with the exception of the communications with residents and their representatives regarding residents’ entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

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

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

Evidence of Implementation: A resident’s personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of resident’s monies, valuables, personal property and possessions as necessary. Residents also had the facility to lock their own wardrobes within their bedroom as necessary. The resident was entitled to bring personal possessions with them, the extent of which was agreed at admission. Additional information concerning property and possessions was also provided to residents within the local information booklet. Money logs were kept and all money logged in and out was recorded by two staff and the residents.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 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 December 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The process for risk-assessing residents for recreational activities, including outdoor activities.
- The process for developing recreational activity programmes.
- The facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to the approved centre.

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.

Evidence of Implementation: There were two activity nurses who provided activities in the approved centre on weekdays. The groups were attended by both community clients and inpatients. Residents had access to television, DVDs, music, books, and art materials. They also had access to a minibus to go on outings both on weekdays and weekends. Facilitators attended the approved centre weekly to run groups such as music and art and crafts. Cork Educational Training had a contract with the approved centre in relation to funding educational programmes. A movie club was run every Tuesday. Walking and gardening groups were available to residents, and the approved centre had a garden where residents regularly enjoyed gardening and the planting of bulbs.

A timetable of recreational activities was displayed and verbally conveyed to residents. Residents were encouraged to suggest activities by submitting feedback forms to a suggestion box. They could also provide verbal suggestions at a weekly meeting facilitated by the activity nurses. Risk assessments in relation to recreational activities were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Staff members facilitating activities liaised with nursing staff daily to check if the risk had changed.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the roles and responsibilities in relation to the support of residents’ religious practices.

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. Facilities were provided within the approved centre for residents’ religious practices. Residents had access to multi-faith chaplains and their contact details were displayed on a noticeboard in the approved centre. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 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 December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the availability of appropriate locations for resident visits.

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

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

Evidence of Implementation: Visiting times were appropriate and reasonable in the approved centre. A separate visitors’ room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. 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. This was communicated to all relevant individuals publicly through a poster at the entrance. Additionally, a couch, soft furnishings and a box of toys were available within the visitors’ room which was suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 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 December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of assessment of resident communication needs.

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

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

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet, telephone, and related devices to enable the sending and receiving of messages and goods unless otherwise risk-assessed with due regard to the residents’ well-being, safety, and health. At the time of inspection, no residents were identified as presenting risks associated with the aforementioned methods of communication. In addition, there were no requirements to examine incoming or outgoing communication of any resident.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
**Regulation 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 December 2016. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the identification and implementation of the resident’s physical, emotional, social, psychological, spiritual, and pain management needs in relation to end of life care.

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

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

The approved centre was compliant with this regulation.
Regulation 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 December 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 not received training in individual care planning.

Monitoring: Residents’ ICPs were not 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 developed by the MDT following a comprehensive assessment, within the designated seven day timeframe of admission. ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. In this regard, a client expectation sheet was consistently completed by residents prior to their ICP meeting. ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

ICPs identified the resources required to provide the care and treatment identified. As the approved centre was a continuing care facility, ICPs were reviewed on a six monthly basis by the MDT in consultation with the resident. Residents being offered a copy of their ICP was consistently documented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
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 December 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The resource requirements of the therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based. A list of all therapeutic services and programmes provided in the approved centre was available to residents. There was a limited number of rooms available on the premises to provide for therapeutic services and programmes. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes in residents’ individual care plans or clinical files.

The services and programmes provided by the approved centre did not meet the assessed needs of all residents. The occupational therapy service was accessed via the local community team on a referral basis only. At the time of the inspection, the approved centre only had access to approximately five hours of occupational therapy time per week. As a result of this limitation in service provision, the occupational therapy service was unable to meet all residents’ needs. Unmet needs were clearly documented in separate occupational therapy screening assessments for residents.

The approved centre was non-compliant with this regulation because there was inadequate provision of occupational therapy services resulting in unmet needs amongst the resident population. Optimal levels of psychosocial functioning were not maintained and restored, 16(2).
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 December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the process for managing resident medications during transfer from the approved centre.

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

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

**Evidence of Implementation:** Full and complete written information for the resident was transferred when they moved from the approved centre to another facility. Also, information was sent in advance upon transfer to the designated and named individual. The following information was issued, with copies retained, as part of the transfer documentation: the resident transfer form, and required medication for the resident during the transfer process. No referral letter accompanied the transfer form and documentation. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. Copies of all records relevant to the resident transfer were retained in the resident’s clinical file.

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

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of general health services and the response to medical emergencies. The policy was last reviewed in December 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to the provision of general health services to residents.
- The resource requirements for general health services, including equipment needs.

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 the provision of general health services and the response to medical emergencies, as set out in the policy.

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

Evidence of Implementation: In relation to response to medical emergencies, the approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Weekly checks were also completed on the resuscitation trolley and on the AED. Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. The general health needs of residents were addressed within the individual care plan. Residents’ general health needs were monitored and assessed, as indicated by the residents’ specific needs, not less than every six months.

The six-monthly general health assessment in the approved centre documented the following: physical examination; personal and family history; Body Mass Index, weight, and waist circumference; blood pressure; smoking status; nutritional status, including diet and physical activity and sedentary lifestyle; medication review; and dental health. For residents on applicable antipsychotic medication, there was an annual assessment of the following: glucose regulation (fasting glucose/HbA1c), blood lipids, Electro-Cardiogram, and prolactin.

Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing, such as laboratory results. Residents could access national screening programmes that were available according to age and gender. Information was provided to residents regarding the national screening programmes available through the approved centre. A smoking
cessation programme was available and offered to all residents upon their admission to the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
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 December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of advocacy arrangements available for residents.

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

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

Evidence of Implementation: The resident information booklet contained details of the following: housekeeping arrangements, including arrangements for personal property and mealtimes; visiting times and arrangements; details of relevant advocacy and voluntary agents; and residents’ rights. Residents in the approved centre were provided with the details of their multi-disciplinary team (MDT). Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, provision of such information may have been prejudicial to the resident’s physical or mental health, well-being, or emotional condition. In this respect, information was provided at individual care plan (ICP) meetings as needed.

The content of medication information sheets included information on indications for use of all medications that were administered to the resident in question, including any possible side-effects from the psychotropic treatment. Information documents regarding this were appropriate and easy to comprehend. Translation services in terms of the provision of information to residents were not required at the time of inspection; however, access to such was available as needed for ongoing admissions to the approved centre.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes pillar.
### Regulation 21: Privacy

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

### INSPECTION FINDINGS

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

- The method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.
- The approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

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

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

**Evidence of Implementation:** Residents were called by their preferred name. The general demeanour of staff and the manner in which staff addressed and communicated with residents was respectful at all times. Staff employed discretion when discussing the resident’s condition or treatment needs. All residents wore clothing that respected their privacy and dignity.

The approved centre’s layout was not always conducive to protecting resident privacy and dignity. The female residents’ corridor, which contained six female bedrooms, also had three staff offices. Furthermore, the day centre activity room was located just beyond this area and outpatients and day hospital attendees accessed this corridor on a regular basis.

All bathroom, shower, toilet, and single bedroom locks had an override function. Bed screening curtains were in situ within shared bedrooms ensuring that residents’ privacy was not compromised. Net curtains were in place in bedrooms that were overlooked by a public area. Noticeboards did not display resident names or other identifiable information. Residents had access to the use of the phone located in the open office of the approved centre. Additionally, residents could close the door while making private phone calls, as required.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the residents’ privacy was appropriately respected at all times, due to access and observations of non-residents while attending day services or an outpatient appointment, 21.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in December 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the identification of hazards and ligature points in the premises.

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

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

Evidence of Implementation: Appropriately sized communal areas were provided within the approved centre. There were two sitting rooms and the smaller sitting room also served as a multi-purpose room. There was suitable heating within the approved centre and temperatures were centrally controlled. Additionally, rooms were ventilated. The sitting rooms were decorated with soft furnishings, ensuring both the reduction of excessive noise and acoustics. Bedrooms were numbered, and offices, toilets, and bathrooms were signposted supporting resident orientation needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces were minimized in the approved centre. Ligature points had not been minimised to the lowest practicable level, however based on risk assessment these were mitigated by the approved centre.

Since the last inspection, the premises had undergone significant renovations, resulting in a good state of repair and decoration both internally and externally. This included power washing of the external building, repair and painting of bedroom walls, and the installation of new wall cladding in bathrooms. The approved centre was clean, hygienic, and free from offensive odours.
There was an adequate number of toilets within the approved centre; however, there were only two showers available for resident use at the time of inspection. This was insufficient for the number of residents within the improved centre. The approved centre did not have a sluice room or a dedicated therapy or examination room however a vacant room or the respite room was available is required. All resident bedrooms were appropriately sized to address residents’ needs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents as there were only two showers available for 21 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 to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in December 2016. The policy/policies addressed requirements of the Judgement Support Framework, with the exception of the process for self-administration of medication.

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

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

Evidence of Implementation: All entries in the MPAR were legible and written in black indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the resident’s care or condition. A prescription was not altered where a change was required. Where there was any alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs, except those for self-administration, were administered by a registered nurse or registered medical practitioner. Additionally, 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.

The expiration date of the medication was checked prior to administration, and expired medications were not administered. Scheduled 2 controlled drugs were checked by two staff members, one of which was a registered nurse, against the delivery form and details were entered on the controlled drug book. Directions to crush medication were only accepted from the resident’s medical practitioner. The medical practitioner provided a documented reason as to why medication had to be crushed. The pharmacist was consulted about the type of preparation to be used.

Medications were stored in an appropriate environment as indicated on the label or packaging of the medication, or as advised by the pharmacist. On one occasion, the medication trolley was found to be unlocked within the clinical room. In addition, medications that were no longer required and due for return to the pharmacy, were stored in an unlocked box within the clinical room. Medication storage
areas were free from damp and mould, clean, free from litter, dust and pests, and free from spillage or breakage. In addition, food and drink were not stored in areas used for the storage of medication. 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) Medication due for return to the pharmacy was observed as being stored in an open box within the clinical room. This was an inappropriate storage practice, 23 (1).
b) The medication trolley did not remain locked at all times when stored within the clinical room. This was an inappropriate storage practice, 23 (1).
c) In three cases, medication administration records had not been signed to indicate that medications had been administered. This was an inappropriate administration practice, 23 (1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in December 2018. It also had an associated safety statement, dated December 2016. The policy and safety statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- Safe handling and disposal of health care risk waste.
- Linen handling.
- Response to sharps or needle stick injuries.
- Availability of staff vaccinations and immunisations.
- Management and reporting of an infection outbreak.
- Support provided to staff following exposure to infectious diseases.
- First aid response requirements.
- Vehicle controls.

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

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

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

The approved centre was compliant with this regulation.
Regulation 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 December 2016. The policy addressed the requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the following:

- The roles and responsibilities in relation to staffing processes within the approved centre.
- The staff rota details and the methods applied for its communication to staff.
- The process for transferring responsibility from one staff member to another.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

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

Evidence of Implementation: The approved centre had access to all core mental health disciplines within the multi-disciplinary team (MDT). However, the occupational therapy input was limited to an average of 5 hours per week; this was insufficient to meet all residents therapy needs. An appropriately qualified staff member was on duty and in charge at all times, and this was documented. There was no written staffing plan for the approved centre.
Health care professionals in the approved centre had up-to-date training in fire safety, Basic Life Support, The Mental Health Act 2001, and Children First. Not all staff, however, had up-to-date training in the management of violence and aggression. Not all staff were trained in the following: dementia care; end of life care; resident rights; risk management – individual, organisational, and care and treatment provision appropriate to the staff role; recovery-centred approaches to mental health care and treatment; incident reporting; and protection of children and vulnerable adults. All staff training however was appropriately documented.

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.

<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 (18)</td>
<td>18 100%</td>
<td>18 100%</td>
<td>18 100%</td>
<td>18 100%</td>
<td>18 100%</td>
</tr>
<tr>
<td>Medical (5)</td>
<td>5 100%</td>
<td>5 100%</td>
<td>4 80%</td>
<td>5 100%</td>
<td>5 100%</td>
</tr>
<tr>
<td>Occupational Therapist (1)</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
</tr>
<tr>
<td>Psychologist (1)</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
<td>1 100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owenacurra</td>
<td>ADON</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Activities Nurse</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Consultant Psychiatrist</td>
<td>0.1 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NCHD</td>
<td>0.3 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.1 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.2 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0.1 WTE</td>
<td></td>
</tr>
</tbody>
</table>

Assistant Director of Nursing (ADON), Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Non-consultant hospital doctor (NCHD)

The approved centre was non-compliant with this regulation for the following reasons:
a) Not all medical professionals had up to date mandatory training in the Professional Management of Aggression and Violence, 26 (4).
b) The number of staff was insufficient to meet the needs of the residents, 26 (2).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

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

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Record retention periods.
- The destruction of records.

The policy did not address the following:

- Those authorised to access and make entries in the residents’ records.
- Record review requirements.
- Residents’ access to resident records.
- The relevant legislative requirements relating to record maintenance; the implementation of the Data Protection Acts, Freedom of Information Acts and associated controls for 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. Not all clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: All residents’ records were secure, up to date, and used in accordance with national guidelines and legislative requirements. Records were not maintained in good order as loose pages were observed in four separate clinical files; another file was too full and bulky. One clinical record was not developed and maintained in logical sequence which caused difficulty when trying to locate the
resident’s individual care plan. Resident records were updated every three to four days or as required, ensuring they were reflective of the residents’ current status and the care and treatment being provided.

All entries to the clinical record were legible, written in black indelible ink and included a date, time and signature. All entries were factual and consistent and where errors were made, properly corrected. All entries made by student or clinical training staff was countersigned by their clinical supervisor. Two appropriate resident identifiers were recorded on all documentation. Records were appropriately secured throughout the approved centre from loss or destruction, tampering, and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) Four files contained loose pages, and one was very bulky. Files were not maintained in good order as required by the regulation, 27 (1).

b) It was difficult to locate the individual care plan of one resident. Therefore, files were not maintained to ensure ease of retrieval as required by the regulation, 27 (1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in December 2016. 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. Not all 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 not been completed to identify opportunities for improving the processes of developing and reviewing policies.

**Evidence of Implementation:** All required policies were reviewed within the required three-year timeframe. Obsolete versions of operating policies and procedures were retained and removed from possible access by staff in the approved centre. The format of policies and procedures was standardised and included: the title of the policy and procedure; the document owner; approvers; reviewers; the scope of the policy and procedure; the date at which the policy was to be implemented, and the scheduled review date, where the document is re-dated after each review. The following, however, were not included: reference number and revision of the policy and procedure, and the total number of pages in the policy and procedure. Generic policies were not used independently but were referenced where applicable. For example, the *Your Service Your Say* policy was included in the complaints policy.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring, and evidence of implementation pillars.
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 December 2016. The policy addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: No complaints had been made and therefore the monitoring pillar was not applicable.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available in the approved centre, and a consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make complaints using the methods detailed in the complaints policy and procedure, which included: verbal; written, e-mail; telephone; and through complaint, feedback or suggestion forms.

The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives, and included: the provision of information about the complaints procedure to residents and their representatives at admission or soon thereafter; the complaints procedure, including how to contact the nominated person, was publicly displayed; and if the nominated person was not based in the approved centre, contact details were publicly displayed. In addition, residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.
Since the previous inspection, there were no minor or formal complaints lodged by residents, family members or representatives.

The approved centre was compliant with this regulation.
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 December 2016. The policy addressed requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- The roles and responsibilities for risk management and the implementation of the risk management policy within the approved centre which included a defined quality and safety oversight and review structure as part of the governance process for managing risk.
- Capacity risks relating to the number of residents in 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. Not all staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate...
that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

**Monitoring:** The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** The person with responsibility for risk in the approved centre was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported and monitored, and clinical risks were documented in the risk register, as appropriate. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation. Additionally, health and safety risks were documented within the risk register, as appropriate. Structural risks, including ligature points were removed or effectively mitigated.

Individual risk assessments were completed prior to and during the following: at admission to identify individual risk factors, including general health risks, risk of absconsion, and risk of self-harm; resident transfer and 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. All incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team (MDT) at their regular meeting.

The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. There was an emergency plan that specified responses by the approved centre staff to possible emergencies. This emergency plan incorporated evacuation procedures.

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

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

### INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
Part 4 of Mental Health Act 2001 was not applicable to this approved centre at the time of the inspection. Please refer to Section 4.3 of this report for areas that were not applicable on this inspection.
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 written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in December 2016, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The file of one resident admitted to the approved centre was reviewed. A key worker system was in place on admission. Admission was on the basis of mental illness or mental disorder, and an admission assessment was completed. Initial assessment included the following: the presenting problem; past psychiatric history; family history; medical history; current and historic medication; current mental health state; and a full and thorough physical examination. The resident’s family member, carer, or advocate was involved in the admission process, with the express consent of said resident.

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

Discharge: The file of one resident discharged from the approved centre was reviewed. The discharge plan included the estimated date of discharge and a reference to early warning signs of relapse and risks. The discharge meeting was attended by the resident in question, key worker, relevant members of the multi-disciplinary team (MDT), and a family member, carer, or advocate, with the given consent of the resident. The discharge assessment included psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and any relevant informational needs. Discharge was coordinated by a key worker, and a preliminary discharge summary were sent to the general practitioner, primary care team, or community mental health team (CMHT) within three days.
A comprehensive discharge summary was issued within 14 days post-discharge. The summary included diagnosis, prognosis, medication, as well as names and contact details of key people for follow-up and risk issues such as any signs of relapse. A family member, carer, or advocate was involved in the discharge process, where appropriate. In addition, a timely follow-up appointment was made where there was a recent history of self-harm or a suicide risk.

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

#### Regulation 16: Therapeutic Services and Programmes

<table>
<thead>
<tr>
<th>Reason ID : 10000279</th>
<th>There was inadequate provision of occupational therapy services resulting in unmet needs amongst the resident population. Optimal levels of psychosocial functioning were not maintained and restored, 16(2).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td><strong>Specific</strong> A business case was submitted in 2018 seeking an OT as new posts require national office approval in the context of development funding. The HOD will continue to work with the OT Manager to ensure the service is maximising existing resources available. We are currently developing and rolling out stepping stones group programme to the Owenacurra unit which will benefit approx 10 - 12 service users.</td>
</tr>
<tr>
<td></td>
<td><strong>Measurable</strong> Ongoing communication with area management team regarding the status of business case. Discussion through regular clinical supervision about priority OT needs and maximising existing resources available.</td>
</tr>
<tr>
<td></td>
<td><strong>Achievable/Realistic</strong> Stepping stones programme is being rolled out now. OT resource is funding dependant.</td>
</tr>
<tr>
<td></td>
<td><strong>Time-bound</strong> 31/10/2019</td>
</tr>
<tr>
<td></td>
<td><strong>Post-Holder(s)</strong> ADON and Area Administrator</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>A business case was submitted in 2018 seeking an OT as new posts require national office approval in the context of development funding. The HOD will continue to work with the OT Manager to ensure the service is maximising existing resources available. This will remain a rolling agenda item for local management meetings. We are currently developing and rolling out stepping stones group programme to the Owenacurra unit which will benefit approx 10 - 12 service users.</td>
</tr>
</tbody>
</table>
Regulation 22: Premises

Reason ID: 10000280

The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents as there were only two showers available for twenty one residents, 22(3).

<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>Funding has been sought and granted for the development of a new wet / shower room.</td>
<td>Work has commenced on the wet / shower room</td>
<td>Achievable and Realistic</td>
<td>11/10/2019</td>
<td>ADON and Maintenance Department</td>
</tr>
</tbody>
</table>

Preventative Action

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One additional shower/wet room will be provided. This will give a total of three showers, consisting of one assisted shower, one non-assisted shower and the new shower/wet room which can be used both assisted and non-assisted. Originally The Owenacurra Centre had one assisted shower, one non-assisted shower and one bathroom. The bath was removed due to the fact that the residents preferred showers.</td>
<td>Work has commenced on the development of a new wet / shower room</td>
<td>Re-configuration programme is reliant on sufficient funding being made available by National Office. Escorting of non-residents will commence immediately</td>
<td>11/10/2019</td>
<td>ADON and Maintenance Department</td>
</tr>
</tbody>
</table>
The new additional shower/wet room returns us to the original number of washing facilities. Centre staff are satisfied that this number is sufficient for the number and profile of residents in the centre.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Reason ID: 10000281
Medication due for return to the pharmacy was observed as being stored in an open box within the clinical room. This was an inappropriate storage practice, 23 (1). The medication trolley did not remain locked at all times when stored within the clinical room. This was an inappropriate storage practice, 23 (1).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>a) Medication due for return to the pharmacy is now in a locked box. b) Memo has been circulated to all nursing staff outlining that the medication trolley is to remain locked at all times when stored in the clinical room. c) ADON and CNM2 have met with nursing staff and explained the importance of the medication administration process and outlined the appropriate recording process.</td>
<td>a) Box is now locked. Quarterly audits have commenced to ensure implementation b) Quarterly audit to ensure implementation c) Quarterly audit to ensure implementation</td>
<td>Achievable and Realistic</td>
<td>27/09/2019</td>
</tr>
</tbody>
</table>

Preventative Action
Quarterly audits to ensure implementation of corrective actions
Through the results of the audits achievable and realistic
27/09/2019
ADON and CNM2
In three cases, medication administration records had not been signed to indicate that medications had been administered. This was an inappropriate administration practice, 23 (1).

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Corrective Action</th>
<th>Preventative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000283</td>
<td>The ADON and CNM2 have met with nursing staff to explain the importance of the medication administration process and outlined the appropriate recording process.</td>
<td>Quarterly audits to ensure implementation</td>
</tr>
<tr>
<td></td>
<td>Quarterly audit to ensure implementation</td>
<td>Through the audit results</td>
</tr>
<tr>
<td></td>
<td>Achievable and realistic</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td></td>
<td>27/09/2019</td>
<td>27/09/2019</td>
</tr>
<tr>
<td></td>
<td>ADON and CNM2</td>
<td>ADON and CNM2</td>
</tr>
</tbody>
</table>
Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID : 10000284</th>
<th>Not all medical professionals had up to date mandatory training in the Professional Management of Aggression and Violence, 26(4).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Currently all medical professionals working in the Owenacurra Centre have up to date training in Professional Management of Aggression and Violence.</td>
<td>Ongoing monitoring of training</td>
<td>Achievable and Realistic</td>
<td>27/09/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing monitoring of training records and requirements</td>
<td>Through regular monitoring of training records</td>
<td>Achievable and realistic</td>
<td>27/09/2019</td>
<td>Heads of Disciplines</td>
</tr>
</tbody>
</table>
**Regulation 21: Privacy**

**Reason ID : 10000286**

The registered proprietor did not ensure that the residents privacy was appropriately respected at all times, due to access and observations of non-residents while attending day services or an outpatient appointment, 21.

<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>ADON has met with Estates in relation to re-configuring the building to ensure the privacy of residents. Scoping drawings have been completed, Architects have been on site. The tendering process has begun. As an immediate measure non-residents and/or outpatients who attend services within the centre will be met on entry to the centre and escorted to the relevant service.</td>
<td>Ongoing communications with the Estates Department. Meeting with centre staff has taken place to ensure implementation of the immediate action.</td>
<td>Escorting of non-residents will commence immediately. Re-configuration programme is ongoing and funding dependant</td>
<td>01/10/2019</td>
<td>ADON and Estates Department</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<tbody>
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<td></td>
<td>ADON has met with Estates in relation to re-configuring the building to ensure the privacy of residents. Scoping drawings have been completed,</td>
<td>Ongoing communications with the Estates Department. Meeting with centre staff has taken place to ensure implementation of</td>
<td>Escorting of non-residents will commence immediately. Re-configuration programme is ongoing and funding dependant</td>
<td>01/10/2019</td>
<td>ADON and Estates Department</td>
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</tbody>
</table>
Architects have been on site. The tendering process has begun. As an immediate measure non-residents and/or outpatients who attend services within the centre will be met on entry to the centre and escorted to the relevant service.
**Regulation 27: Maintenance of Records**

**Reason ID: 10000287**

Four files contained loose pages, and one was very bulky. Files were not maintained in good order as required by the regulation, 27 (1). It was difficult to locate the individual care plan of one resident. Therefore, files were not maintained to ensure ease of retrieval as required by the regulation, 27 (1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff will be encouraged to complete HSELand online module Healthcare Records Management if not already completed. Bulky files will be condensed making it easier to retrieve documents</td>
<td>Audits will commence from 2nd September 2019 and will be six monthly thereafter</td>
<td>Achievable and Realistic</td>
<td>02/09/2019</td>
<td>ADON and CNM2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Through audits of staff training</td>
<td>Audits will commenced 2nd September and will be six monthly thereafter</td>
<td>Achievable and Realistic</td>
<td>02/09/2019</td>
<td>Head of Disciplines</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

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

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

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

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

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

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

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

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

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

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