Acute Psychiatric Unit, Tallaght Hospital

ID Number: AC0012

2019 Approved Centre Inspection Report (Mental Health Act 2001)

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

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

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Previous Inspection Date:
13 – 16 November 2018

Inspection Date:
16 – 19 July 2019

Inspection Type:
Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Wednesday 22 January 2020

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

1.0 Inspector of Mental Health Services – Review of Findings ........................................5  
2.0 Quality Initiatives ........................................................................................................10  
3.0 Overview of the Approved Centre .............................................................................11  
   3.1 Description of approved centre .............................................................................11  
   3.2 Governance ...........................................................................................................11  
   3.3 Reporting on the National Clinical Guidelines ....................................................13  
4.0 Compliance ................................................................................................................14  
   4.1 Non-compliant areas on this inspection .................................................................14  
   4.2 Areas of compliance rated “excellent” on this inspection ......................................15  
   4.3 Areas that were not applicable on this inspection .................................................15  
5.0 Service-user Experience ..............................................................................................16  
6.0 Feedback Meeting .......................................................................................................17  
7.0 Inspection Findings – Regulations ............................................................................18  
8.0 Inspection Findings – Rules .......................................................................................62  
9.0 Inspection Findings – Mental Health Act 2001 ..........................................................67  
10.0 Inspection Findings – Codes of Practice .................................................................70  

Appendix 1 Background to the inspection process ......................................................... Error! Bookmark not defined.
1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The approved centre was a 52-bed acute mental health unit located on the ground floor of Tallaght University Hospital. It consisted of three units: Cedar (female admissions), Rowan (male admissions) and Aspen (high observations). Residents were under the care of twelve different multi-disciplinary teams (MDTs), through an in-reach model of care. The MDT specialities included ten General Adult teams, one Psychiatry of Later Life team and one Rehabilitation and Recovery team.

There has been an overall decrease in compliance with regulations, rules and codes of practice from 63% compliance in 2017 to 56% compliance in 2019. For three consecutive years, the approved centre remained non-compliant with the Rules Governing the Use of Seclusion, Part 4 of the Mental Health Act: Consent to Treatment, one code of practice, and six regulations. The non-compliance with Regulation 15: Individual Care Plan was rated critical risk on this inspection. Three compliances with regulations were rated excellent.

Conditions to registration

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

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

Finding on this inspection: The approved centre was not in breach of Condition 1. The approved centre was non-compliant with Regulation 15: Individual Care Plan, risk rated critical, at the time of inspection.

Condition 2: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 2. The approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.
Safety in the approved centre

- Food safety audits had been completed regularly. There were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Hygiene was maintained to support food safety requirements.
- Hazards were minimised and although there were some ligature points, these had been mitigated.
- Medication was ordered and stored in a safe manner.
- There was an emergency plan in place which incorporated evacuation procedures.

However:

- There were a number of errors in the prescription and administration of medication.
- Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the management of violence and aggression, the Mental Health Act 2001 and Children First. This was particularly apparent in the training records of consultant psychiatrists and non-consultant hospital doctors.
- Hard and rough edged frames were observed around windows of the seclusion room.

Appropriate care and treatment of residents

- The approved centre had a comprehensive weekly therapeutic occupational therapy programme, which included relaxation, wellness planning, breakfast club, self-care, plant pot decoration and cookery groups. External providers including a yoga instructor, a music therapist, and an exercise instructor also facilitated groups. A psychology group, facilitated by two psychologists within the sector teams, was held weekly. All residents had access to social work, occupational therapy and psychology on a one-to-one basis where required. Services were provided in a separate dedicated room containing facilities and space for individual and group therapies.
- Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with individual care plans (ICPs).
- In four of five clinical files inspected, each six-monthly general health assessment had documented the residents’ family and personal history. Residents on antipsychotic medication were assessed on glucose regulation including fasting, glucose/Hba1c, blood lipids, prolactin, and electrocardiogram, within the appropriate timeframe.

However:

- Due to significant concerns regarding the individual care planning process, Regulation 15: Individual Care Plan was non-compliant and was risk rated as critical. A number of ICPs were not developed by the MDT, did not identify appropriate goals, did not specify the care and treatment required to meet the identified goals, and did not identify specific resources required to provide the care and treatment identified. Two ICPs were not reviewed on a weekly basis. There was no evidence that ten of the residents were offered a copy of their ICP, including any reviews.
• One clinical file inspected indicated that the resident had not received a physical examination within the six month time frame. Not all six-monthly general health assessments documented all of the following: a physical examination, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, a medication review or dental health.

• The discharge process for one resident did not adhere to policy; assessment did not include a comprehensive risk assessment and risk management plan, there was no evidence that a preliminary discharge summary had been sent to the general practitioner/primary care/community mental health team within three days, or that a comprehensive discharge summary was issued within 14 days.

Respect for residents’ privacy, dignity and autonomy

• Appropriate and reasonable visiting times were publicly displayed in the approved centre. There were a number of suitable visiting areas provided where residents could meet visitors in private.

• Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. At least two clinical staff were in attendance at all times when searches were conducted and they were implemented with due regard to the resident’s dignity, privacy and gender.

• All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Where residents shared a room, bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls. Rooms overlooked by public areas had opaque glass.

• The approved centre was adequately heated and ventilated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. All resident bedrooms were appropriately sized to address residents’ needs. There was sufficient space for residents to move about, including outdoor spaces.

• The approved centre was kept in a good state of repair externally. Significant improvements were made internally since the last inspection. Refurbishment works were ongoing at the time of inspection. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was a cleaning schedule implemented within the approved centre.

• There were clear signs in prominent positions where CCTV cameras were located. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image on a tape, disc, hard drive or in any other form.

However:

• Not all internal areas of the approved centre were in a good state of repair at the time of the inspection, notably the bathrooms in Aspen, which had not yet been refurbished. The recently refurbished bathrooms in Cedar Ward did not contain hand dryers or tissue paper for residents to dry their hands. The ceiling tiles in the games room were loose in two areas, and a number of ceiling
tiles were stained. The internal garden in Aspen Ward was in a poor state of repair and some of the old flooring in the approved centre was scuffed and in need of replacement.

- There was no emergency female underwear included in the supply of emergency clothing.
- CCTV cameras used to observe a resident transmitted images to a monitor which was not viewed solely by the health professional responsible for the resident. The monitor in Aspen Ward could be seen by any other person on the ward.
- Records were secure but not maintained and used in accordance with national guidelines and legislative requirements. Records were not always up to date or in good order, and loose pages were observed in one file. Not all resident records reviewed were reflective of the residents’ current status and care and treatment being provided. All records were not written legibly in black, indelible ink and were readable when photocopied. All record entries did not document the time of entry, and where errors were made, they were not properly corrected.
- Seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. A number of dead flies and dust were observed in the seclusion room in Cedar Ward.
- In the case of one resident, the approved centre was in breach of Part 4 of the Mental Health Act 2001: Consent to Treatment.

**Responsiveness to residents’ needs**

- Residents had at least two choices for meals. Food, including modified consistency diets, was presented in an appealing manner.
- A group called ‘Be Well Feel Well’ was facilitated by one of the consultant psychiatrists. The focus of this group included a number of topics, such as healthy eating, tobacco interventions and cessation, alcohol use and physical activity.
- The approved centre provided access to recreational activities on weekdays and during the weekend. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity.
- There was a robust complaints procedure in place.
- Written information was provided for residents about the approved centre and residents’ diagnoses and medications.

However:

- A resident’s personal property and possessions were not safeguarded when the approved centre assumed responsibility for them. On review of items within the locked cabinet in the clinical room in Cedar Ward, one item belonging to a resident which was documented as being kept in the cabinet was missing. Additionally, the locked cabinet within Cedar Ward also contained the property of one resident who was deceased.
Governance of the approved centre

- The approved centre was part of Dublin South, Kildare & West Wicklow, Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 7, and was governed under the Dublin South Central Mental Health Services. The area mental health services governance included the Mental Health Area Management Team and the Mental Health Quality and Safety Committee. The approved centre had a local Unit Management meeting, in which the heads of discipline met monthly to discuss key operational issues such as regulatory compliance, quality initiatives, monitoring and risk management.

- The HSE had a Service Level agreement (SLA) with Tallaght Hospital and any issues in relation to the arrangement of the provision of service functions and facilities were discussed with the Tallaght Management Team at quarterly estate meetings. This included services such as catering, pharmacy, technical services and cleaning.

- The person with responsibility for risk was identified and known by all staff. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns occurring in the service. The approved centre had a risk register.

However:

- The approved centre had a Policy Group, but some policies were out of date, not in place, or did not meet the elements of the Judgement Support Framework’s processes pillar.

- The approved centre had developed an auditing and analysis schedule; however, the schedule had not been fully implemented.

- The mandatory training progress update provided by the approved centre indicated that the training levels of consultant psychiatrists and medical personnel were low.
The following quality initiatives were identified on this inspection:

1. Establishment of a ‘Fresh Air’ group, which aimed to improve residents’ physical health. The approved centre had plans to implement a Tobacco Free Campus in September 2019.

2. Implementation of a hand hygiene initiative. This included the facilitation of hygiene audit training for clinical nurse managers, the launch of a hand hygiene awareness week, and the completion of internal hygiene audits.

3. Completion of a nursing handover review, which resulted in the development of a new formalised nursing handover sheet utilising the Identify, Situation, Background, Assessment and Recommendation (ISBAR) process.

4. Development of a new nursing assessment and care plan document, which aimed to facilitate resident involvement in conjunction with the integration of standardised assessment tools.

5. Implementation of a new physical health assessment template through a national piloting process.

6. Completion of upgrades to the premises, which included internal wall painting and the renovation of toilet and shower rooms within Cedar and Rowan Units. The approved centre also had plans to upgrade the toilet and shower rooms in the Aspen Ward, along with the renovation of the main reception area and the occupational therapy kitchen.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the ground floor of Tallaght University Hospital. The unit was clearly signposted and accessible from the main hospital lobby. The approved centre consisted of three units: Cedar (female admissions), Rowan (male admissions) and Aspen (high observations), which accommodated 52 residents at full capacity. The doors to all three units were locked and entry was by requested access or swipe card.

The accommodation facilities on each of the three units consisted of shared dormitories, with a limited number of single bedrooms. Cedar and Rowan unit had access to a shared corridor which contained a dining room, laundry room and a variety of multi-functional rooms such as a games room, family room and reading room. An art room, therapy room and snoezelen room were available for therapeutic activities. The Aspen unit had a separate open plan dining and sitting room. The approved centre had two enclosed gardens; one for both the Cedar and Rowan units and one for the Aspen unit.

Residents were under the care of twelve different multi-disciplinary teams, through an in-reach model of care. The multi-disciplinary team specialities included ten General Adult teams, one Psychiatry of Later Life team and one Rehabilitation and Recovery team.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>52</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>49</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>8</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>10</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 part of Dublin South, Kildare & West Wicklow, Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 7. The approved centre was governed under the Dublin South Central Mental Health Services. The area mental health services governance processes encompassed two core meetings: the Mental Health Area Management Team meeting and the Mental Health Quality and Safety Committee meeting. Both meetings were scheduled regularly and the meeting minutes evidenced discussions on key issues, such as: risk management, quality initiatives, complaints/compliments, policies/procedures/protocols/guidelines, regulatory compliance, resource requirements and performance.
monitoring. The approved centre had a local Unit Management meeting, in which the heads of disciplines met monthly to discuss key operational issues such as regulatory compliance, quality initiatives, monitoring and risk management. Additional working groups and committees within the approved centre reported into this forum. This included a local Quality and Safety Committee meeting, Compliance meeting, Individual Care Planning Review group, Policy group and Feel Well Be Well group.

The approved centre was leased from Tallaght University Hospital. A Service Level agreement (SLA) was maintained and any issues in relation to the arrangement of the provision of service functions and facilities were discussed with the Tallaght Management Team at quarterly estate meetings. This included services such as catering, pharmacy, technical services and cleaning.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs. Despite on-going efforts in the area of mandatory training, not all staff had up-to-date training on basic life support, fire safety, management of violence and aggression, the Mental Health Act 2001, and Children First. The mandatory training progress update provided by the approved centre indicated that the training levels of consultant psychiatrists and medical personnel were particularly low.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF). Incidents were reviewed to identify any trends or patterns occurring in the service.

The approved centre had a Policy Group, with input from various members of the multi-disciplinary team. However, three of the approved centre’s policies and procedures, which required a three-yearly review under Regulation 29: Operating Policies and Procedures, were out of date. This included; Regulation 11: Visits, Regulation 12: Communication, and Regulation 26: Staffing. This had been identified as an issue by the service as it was logged as a risk on the approved centre’s risk register. Several other regulations did not have any written operational policies and procedures. Recently updated policies and procedures continued to lack some of the requirements specified within the Judgement Support Framework’s processes pillar.

Monitoring was identified as an area requiring improvement. The approved centre had developed an auditing and analysis schedule. However, the schedule had not been fully implemented.

Sixteen areas were rated as non-compliant, in comparison with seventeen non-compliances in 2018. Due to significant concerns regarding the individual care planning process, Regulation 15: Individual Care Plan was non-compliant and was risk rated as critical. Three areas were rated as excellent. Significant work had been completed to address previous inspection findings regarding the premises. This included the painting of internal walls and the upgrade of the toilets and showers in Cedar and Rowan units. The approved centre also had plans to upgrade the toilet and shower rooms in the Aspen Ward, along with the renovation of the main reception area and the occupational therapy kitchen. Additional quality improvements included the establishment of a ‘Fresh Air’ group and the implementation of a hand hygiene initiative.
The Mental Health Commission’s governance questionnaire was issued to the approved centre’s heads of discipline in advance of the inspection. Five completed questionnaires were returned: Clinical Director, Occupational Therapy Manager, Principal Psychologist, Assistant Director of Nursing, and Clinical Specialist Speech and Language Therapist. The questionnaires outlined regular engagement with staff and clear lines of responsibility. Visits to the approved centre ranged from daily to weekly. Limited training opportunities, ligature points, continued dominance of the medical model, staff shortages and recruitment challenges were identified as the main operational risks within the submitted questionnaires.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>✓</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>Low</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✓</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001 - Consent to Treatment</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.
4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
</tbody>
</table>

4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>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>
</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 nine residents and three family members during the inspection. Additionally, one ‘Your Views’ Mental Health Commission resident questionnaire was returned to the inspection team. Generally, residents were complimentary of the care and treatment provided. Residents reported that the food and activities provided by the approved centre were good, while staff were described positively by all.

One resident expressed dissatisfaction with the inconsistency in the scheduling of their individual care plan (ICP) meetings. Any clinical issues raised, during the resident and family member meetings, were discussed with the relevant discipline, with the consent of the complainant.

The inspection team also had the opportunity to meet with the IAN representative. The IAN feedback indicated that residents were aware of their keyworker and their individual care plan. Areas of concern included residents’ limited time with their Consultant Psychiatrist and ambiguity regarding their leave from the approved centre.
6.0 Feedback Meeting

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

- Operations Manager/Acting Head of Mental Health
- Clinical Director
- Area Director of Nursing
- Principal Clinical Psychologist
- Occupational Therapy Manager
- Director of Nursing
- Consultant Psychiatrists x7
- Acting Clinical Nurse Manager III
- Clinical Nurse Manager II x2

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. Any relevant information provided to the inspection team at the feedback meeting was included within 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 June 2015. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** A minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs, were used. Identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare, therapeutic services, and programmes. A system for identifying residents with the same or similar name was in place.

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 did not have a written policy in relation to food and nutrition.

Training and Education: There was no policy for staff to read, understand, or articulate. Relevant staff interviewed were able to articulate the processes for food and nutrition.

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

Evidence of Implementation: Hot meals were offered daily. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. Weight charts were implemented, monitored, and acted upon for residents, where appropriate. A group called ‘Be Well Feel Well’ was facilitated by one of the consultant psychiatrists. The focus of this group included a number of topics, such as healthy eating, tobacco interventions and cessation, alcohol use, and physical activity. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education 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 July 2015. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food 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 not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in the main hospital kitchen and was transported to the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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 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 did not have a written policy in relation to residents’ clothing.

Training and Education: There was no policy for staff to read, understand, or articulate. Relevant staff interviewed were able to articulate the processes for residents’ clothing.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. All residents had storage areas for their clothes. Residents had an adequate supply of individualised clothing. Residents were encouraged to send laundry home for family members to undertake. Where residents were unable to do so, a laundry room was available for use on Cedar Ward.

When required, residents did not have access to a full supply of emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. There was no emergency female underwear included in the supply. This was rectified before the end of inspection and it was agreed that this would be included within the ordering and monitoring going forward.

The approved centre was non-compliant with this regulation because the approved centre did not have an adequate supply of emergency clothing as the supply did not include female underwear, 7(1).
### 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 Sept 2017. The policy addressed requirements of the Judgement Support Framework, with the exception of the process to allow residents access to and control over their personal property and possessions, unless this poses a danger to the resident or others, as indicated by an individual risk assessment and the resident’s individual care plan.

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

**Monitoring:** 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 not safeguarded when the approved centre assumed responsibility for them. On review of items within the locked cabinet in the clinical room in Cedar Ward, one item belonging to a resident which was documented as being kept in the cabinet was missing. Staff at the time were unable to account for the missing item. The item was later found by staff. Additionally, the locked cabinet within Cedar Ward also contained the property of one resident who was deceased. On review of the locked safes within Rowan and Aspen Wards, all money and valuables were present and correlated with the log book.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP).

Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.
The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that adequate provision for the safe keeping of one resident’s valuables was made as:

a) One item belonging to a resident on Cedar Ward, which was documented as being kept in the locked cabinet, was missing on inspection. The item was later found by staff, 8(6).

b) The locked cabinet within Cedar Ward contained the property of one resident who was deceased, 8(6).
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 September 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake and attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Recreational activities provided included TV and DVDs, books and board games. Information was provided to residents in an accessible format, which was appropriate to their individual needs. The timetable for activities was displayed. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Activities were developed, maintained, and implemented with resident involvement. Resident feedback and resident preferences were taken into account. Records of resident attendance at events were maintained in group records or in the clinical files.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in April 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 not reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents’ religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring 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 and procedures in relation to visits. The policy was last reviewed in June 2016. The policy and procedures addressed requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

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

Monitoring: There were no current restrictions on residents’ rights to receive visitors. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. There were a number of suitable visiting areas provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

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

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
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 policy and procedures in relation to resident communication. The policy was last reviewed in June 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 communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, e-mail, internet, and telephone, if they wished. Individual risk assessments completed, as deemed appropriate, in relation to any risks associated with residents’ external communication was not documented in one resident’s individual care plan.

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 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 policies and procedures in relation to the implementation of resident searches. The Searches policy was last reviewed in September 2018 and the Illicit Substances and Alcohol policy was last reviewed in April 2018. The policies and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Risk was assessed prior to a search of a resident or their property. Resident consent was sought prior to all searches, which was documented. Where consent was not received, the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents. Staff informed residents of what was happening during a search and why.
At least two clinical staff were in attendance at all times when searches were conducted. Searches were implemented with due regard to the resident’s dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched.

A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and protocols in relation to care of the dying. The policies were last reviewed in April 2019.

The policies addressed requirements of the Judgement Support Framework, with the following exceptions:

- Advance directives in relation to end of life care, Do Not Attempt Resuscitation (DNAR) orders, and residents’ religious and cultural end of life preferences.
- Ensuring that the approved centre was informed in the event of the death of a resident who had been transferred somewhere else (e.g. for general health care services).

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in September 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Ten ICPs were reviewed as part of the inspection. A key worker was identified to ensure continuity in the implementation of a resident’s ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All inspected ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address immediate needs of resident. Eight out of the ten inspected ICPs were not developed by the MDT following a comprehensive assessment, and three ICPs were not developed within seven days of admission.

The ICPs identified the resident’s assessed needs. Two ICP’s did not identify appropriate goals and three ICPs did not specify the care and treatment required to meet the identified goals. Eight out of ten ICPs did not identify specific resources required to provide the care and treatment identified. Two ICPs did not include a risk management plan.

Seven ICPs were not reviewed by the multidisciplinary team in consultation with the resident. Two ICPs were not reviewed on a weekly basis. Residents had access to their ICPs and were kept informed of any changes. There was no evidence that ten of the residents were offered a copy of their ICP, including any reviews. Where a resident declined or refused a copy of their ICP, this was not recorded, including the reason, if given in nine ICPs. Four ICPs did not include a preliminary discharge plan, where deemed appropriate.
The approved centre was non-compliant with this regulation for the following reasons:

a) Three ICPs were not developed within seven days of admission to the approved centre.
b) Eight ICPs were not developed by the multi-disciplinary team (MDT) and seven ICPs were not reviewed by the MDT.
c) Two ICPs were not reviewed on a weekly basis.
d) Two ICPs did not identify appropriate goals.
e) Three ICPs did not specify the care and treatment required to meet the identified goals.
f) Eight out of ten ICPs did not identify specific resources required to provide the care and treatment identified.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in May 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Therapeutic programmes and services were appropriate and met the assessed needs of residents, as documented in their individual care plans (ICP). Programmes and services were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Programmes and services were evidence-based.

The approved centre had a comprehensive weekly therapeutic occupational therapy programme. Therapeutic groups on this programme included relaxation, wellness planning, breakfast club, self-care, plant pot decoration, and cookery groups. External providers including a yoga instructor, a music therapist, and an exercise instructor also facilitated groups. A psychology group, facilitated by two psychologists within the sector teams, was held weekly.

All residents had access to social work, occupational therapy and psychology on a one-to-one basis where required. Services were provided in a separate dedicated room containing facilities and space for individual and group therapies. Where no internal service existed, an appropriate external service with an approved, qualified health professional was provided.

A list of services and programmes provided in the approved centre was available to residents. A record was maintained of participation, engagement, and outcomes achieved through the therapeutic programme in residents' ICPs or clinical files.

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 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 written policies and procedures in relation to the transfer of residents, both policies were last reviewed in July 2017. The policies included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre in an emergency was examined. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Information accompanied the resident upon transfer to a named individual. The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident’s needs.

Relevant documentation was issued as part of the transfer, with copies retained, including a referral letter and a copy of the resident’s Medication, Prescription, and Administration Record. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident’s clinical file.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in July 2015. The medical emergencies policy was last reviewed in September 2016. The policies and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The management of emergency response equipment, including resuscitation trolley and Automated External Defibrillator (AED).
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The incorporation of general health needs into the resident individual care plan.
- The referral process for residents’ general health needs.

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

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with individual care plans. Five clinical files were inspected in relation to residents’ six monthly general health assessments. One of the files indicated that the resident had not received a physical examination within the required timeframe.
Of the remaining four clinical files, each six-monthly general health assessment had documented the residents’ family and personal history. However, all six-monthly general health assessments did not document the following: a physical examination, BMI, weight, and waist circumference, blood pressure, smoking status, nutritional status, a medication review, or dental health. Residents on antipsychotic medication were assessed on glucose regulation including fasting, glucose/Hba1c, blood lipids, prolactin, and electrocardiogram, within the appropriate timeframe.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre.

Residents had access to smoking-cessation programmes and supports.

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

a) A six monthly general health assessment was not documented for one resident, within the six-month timeframe, 19(1)(b).

b) Four six-monthly general health assessments did not document at least one of the following requirements; the residents’ BMI, weight, and waist circumference, blood pressure, smoking status, nutritional status, a medication review, or dental health, 19(1)(a).
Regulation 20: Provision of Information to Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in April 2019. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

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

Residents were provided with details of their multi-disciplinary teams. Residents were provided with written and verbal information on diagnosis, unless, in the treating psychiatrists’ view, the provision of such information might be prejudicial to the residents’ well-being. Information was provided to residents on the likely adverse effects of treatment including risks and other potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to residents’ needs. The information provided within the approved centre was evidence based and was appropriately reviewed. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and monitoring pillars.
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 relation to resident privacy, which was last reviewed in July 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** Residents were addressed by their preferred names, and staff members interacted with residents in a respectful manner. Staff were discreet when discussing residents' condition or treatment needs. Residents wore clothing that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Where residents shared a room, bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

Rooms overlooked by public areas had opaque glass. The curtains on the windows in three of the dormitory rooms on Cedar Ward did not close fully and therefore daylight was entering bedrooms from early morning and late evening. This was not conducive to resident dignity. This was rectified by staff during the inspection.

The approved centre was non-compliant with this regulation because the residents’ dignity had not been appropriately respected at all times as the curtains in three dormitories in Cedar Ward did not close fully, (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.
(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to its premises.

Training and Education: There was no policy for staff to read, understand, or articulate. Relevant staff
interviewed could articulate the processes relating to the maintenance of the premises.

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

Evidence of Implementation: The approved centre was adequately heated, and ventilated. The lighting in
all communal rooms did not suit the needs of residents and staff. The lighting in the games room was not
sufficiently bright and positioned to facilitate reading and other activities. Residents had access to
personal space, and private and communal rooms were appropriately sized and furnished to remove
excessive noise. There was a sufficient number of toilets and showers for residents in the approved centre.
All resident bedrooms were appropriately sized to address residents’ needs. There was sufficient space
for residents to move about, including outdoor spaces.

Hazards and ligature points had been minimised. The approved centre was kept in a good state of repair
externally. Significant improvements were made internally since the last inspection. Refurbishment works
were ongoing at the time of inspection. However, not all internal areas of the approved centre were in
a good state of repair at the time of the inspection. Most notably the bathrooms in Aspen, which had not
yet been refurbished but the approved centre had plans to upgrade this area. The recently refurbished
bathrooms in Cedar Ward did not contain hand dryers or tissue paper for residents to dry their hands.
This was rectified at the end of the first day of the inspection. The ceiling tiles in the games room were
loose in two areas, and a number of ceiling tiles were stained. The internal garden in Aspen Ward was in
a poor state of repair and some of the old flooring in the approved centre was scuffed and in need of replacement.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was a cleaning schedule implemented within the approved centre. The approved centre was clean, hygienic, and free from offensive odours. With the exception of the seclusion room which was dusty. This was promptly addressed by the service. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed.

Back-up power was available to the approved centre. Heating could not be safely controlled in the resident’s own room but could be adjusted centrally by contacting the maintenance department. The approved centre had a designated sluice room, a designated cleaning room, and a designated laundry room. The approved centre provided assisted devices and equipment to address resident needs. Remote or isolated areas of the approved centre were monitored.

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

a) The approved centre was not maintained in good decorative condition as the ceiling tiles in the games room were loose in two areas, a number of ceiling tiles were stained, the internal garden in Aspen Ward was in a poor state of repair, and some of the old flooring in the approved centre was scuffed and in need of replacement, 22(1)(a).

b) The lighting in the games room was not sufficiently bright and positioned to facilitate reading and other activities, 22(1)(b).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication. It was last reviewed in July 2017. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for self-administration of medication.
- The processes for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.
- The process for reviewing resident medication.

Training and Education: Not all nursing, medical or pharmacy staff had signed the signature log to indicate that they had read and understood the policy. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and 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 not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. A record of allergies or sensitivities to any medications, including if the resident had no allergies, had not been recorded for one resident. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of dosage, and frequency of medication. The Medical Council Registration Number of medical practitioner prescribing medication to the resident was documented in each MPAR.

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

One MPAR did not record the stop date for each medication. Not all medications administered to residents were recorded. There were gaps in the administration records pertaining to two residents. It was not
known, therefore, if the residents had received or refused the prescribed medication or if this medication had been withheld.

The medication trolley and medication administration cupboard remained locked at all times and secured in a locked room. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Refrigerators used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. An inventory of medications was conducted on a weekly basis checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.

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

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

a) A record of allergies or sensitivities to any medications, including if the resident had no allergies, had not been recorded for one resident, 23(2).

b) One MPAR did not record the stop date for each discontinued medication, 23(2).

c) Not all medications administered to residents were recorded in the MPAR. There were gaps in the administration records pertaining to two residents, 23(2).
**Regulation 24: Health and Safety**

<table>
<thead>
<tr>
<th>COMPLIANT</th>
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</table>

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 safety statement, dated February 2019, which addressed all requirements of the *Judgement Support Framework*, including:

- Specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- Safety representative roles.
- Linen handling.
- Covering of cuts and abrasions.
- Falls prevention initiatives.
- Vehicle controls.

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

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

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

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

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:
   a. it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
   b. it shall be clearly labelled and be evident;
   c. the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
   d. it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
   e. it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in April 2019. The policy addressed most of the requirements of the Judgement Support Framework, including the purpose and function of using CCTV for observing residents in the approved centre.

However, the policy did not include the following:

- The roles and responsibilities for the use of CCTV within the approved centre.
- The maintenance of CCTV cameras by the approved centre.
- The disclosure of the existence and usage of CCTV or other monitoring devices to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.
- The process to cease monitoring a resident using CCTV in certain circumstances.

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

Monitoring: The quality of the CCTV images was not checked regularly to ensure that the equipment was operating appropriately. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras (or other monitoring systems) were located. Residents were only monitored for the purposes of ensuring their health, safety, and welfare. CCTV was not used to monitor a resident if they started to act in a way...
that compromised their dignity. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form. CCTV cameras used to observe a resident transmitted images to a monitor that was not viewed solely by the health professional responsible for the resident. The monitor in Aspen Ward could be seen by any other person on the ward. The usage of CCTV was disclosed to the Mental Health Commission.

The approved centre was non-compliant with this regulation because the CCTV monitor in Aspen Ward could be viewed by any person in Aspen Ward and not solely the healthcare professionals responsible for ensuring the health and welfare of the residents, 25(1)(a).
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in July 2015. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

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

However, the policy and procedures did not address the process for transferring responsibility from one staff member to another.

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

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

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

Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. This rota indicated that an appropriately qualified staff member was on duty and in charge at all times.
The numbers and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was not available within the approved centre. Staff were not trained in line with the assessed needs of the resident group profile and of individual residents. Staff were trained in areas such as risk management and treatment, incident reporting, manual handling, infection control and prevention, recovery-centred approaches to mental health care and treatment, resident rights, caring for residents with an intellectual disability, and the protection of children and vulnerable adults, but were not trained in dementia care and end of life care. All staff training was documented and staff training logs were maintained.

Not all health care staff had received up to date mandatory training. The following is a table of staff mandatory training levels in the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (51)</td>
<td>43</td>
<td>84%</td>
<td>43</td>
<td>84%</td>
<td>45</td>
</tr>
<tr>
<td>Consultant Psychiatrist (15)</td>
<td>9</td>
<td>60%</td>
<td>6</td>
<td>40%</td>
<td>5</td>
</tr>
<tr>
<td>Medical (24)</td>
<td>7</td>
<td>29%</td>
<td>6</td>
<td>25%</td>
<td>4</td>
</tr>
<tr>
<td>Occupational Therapist (2)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Social Worker (9)</td>
<td>9</td>
<td>100%</td>
<td>9</td>
<td>100%</td>
<td>9</td>
</tr>
<tr>
<td>Psychologist (7)</td>
<td>6</td>
<td>86%</td>
<td>7</td>
<td>100%</td>
<td>6</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cedar Ward</td>
<td>ADON (Mon-Fri)</td>
<td>1 (shared)</td>
<td>1 (shared)</td>
</tr>
<tr>
<td></td>
<td>CNM 3</td>
<td>1 (shared)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM 1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1 (shared)</td>
<td></td>
</tr>
</tbody>
</table>
Assistant Director of Nursing (ADON), Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA).

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the management of violence and aggression, and Children First, 26(4).

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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in April 2019. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

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

The policy and procedures did not address the following:

- Those authorised to access and make entries in the residents’ records.
- Record review requirements.
- Privacy and confidentiality of resident record and content.
- Residents’ access to resident records.
- The destruction of records.
- The process for making a retrospective entry in residents’ records.
- Retention of inspection reports relating to food safety, health and safety and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. Not all clinical staff 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: Records were secure and were constructed but not maintained, and used in accordance with national guidelines and legislative requirements. Records were not up to date or in
good order, loose pages were observed in one file. A record was initiated for every resident but not all resident records reviewed were reflective of the residents’ current status and care and treatment being provided. Resident records were physically stored together, where possible. Not all resident records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, however two appropriate resident identifiers were not recorded on all documentation.

Only authorised staff made entries in residents’ records, or specific sections therein. All records were not written legibly in black, indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Not all resident records reviewed were not maintained appropriately. All record entries did not document the time of entry, and where errors were made, they were not properly corrected.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to 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) Records were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval as loose pages were observed, clinical files were not maintained in a logical sequence, and not all records contained an appropriate resident identifier, 27(1).

b) One record was not kept up-to-date as the record was not reflective of the resident’s current status, care and treatment being provided, 27(1).

c) All record entries to the clinical file did not document the time of entry and two appropriate resident identifiers were not recorded on all documentation, 27(1).

d) The approved centre’s policy did not include reference to access to records and destruction of records, 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

A documented electronic register of all residents admitted to the approved centre was available. The electronic register of residents was made available to the Mental Health Commission, when requested.

The register of residents contained the following information: full name, address, gender, date of birth, country of birth, next of kin or representative(s), admission date, and discharge date, as applicable and diagnosis on admission. The status of the resident (voluntary or involuntary) was not documented on the register. In addition, discharge diagnosis was not consistently documented.

The register of residents was not up-to-date at the time of inspection.

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

a) The register of residents was not up to date, 28(1).
b) Resident status (voluntary or involuntary) was not documented on the register, 28(2).
c) Discharge diagnosis was not consistently documented, 28(2).
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in July 2015. It addressed requirements of the Judgement Support Framework, with the exception of the standardised operating policy and procedure layout used by 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines.

Generic policies were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre has a written statement adopting the generic policy.

The approved centre was non-compliant with this regulation because the Regulation 11: Visits, Regulation 12: Communication and Regulation 26: Staffing policies had not been reviewed within the recommended 3-year period.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in July 2017. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in June 2018. The policy and procedures 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: Not all staff had signed the signature log to indicate that they had read and understood the policy relating to complaints. Relevant staff were trained on the complaints management process and could articulate the processes for making, handling, and investigating complaints as set out in the policy.

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

Evidence of Implementation: Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. Residents and their representatives were assisted to make complaints using appropriate methods and were facilitated to access an advocate. There was a nominated complaints officer who was responsible for dealing with complaints, and who was clearly identified. There was also a method for addressing minor complaints. Where services, care, or treatment were provided on behalf of the approved centre by an external party, the nominated person was responsible for the full implementation of the approved centre’s complaints management process.
All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, and outcomes. This was kept distinct from the resident’s individual care plan.

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

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 32: Risk Management Procedures

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
   (i) resident absent without leave,
   (ii) suicide and self harm,
   (iii) assault,
   (iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policies in relation to risk management and incident management procedures. 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.

However, the policy did not address the following:

- The responsibilities of the registered proprietor.
- The person responsible for the completion of six-monthly incident summary reports.
- Organisational risks.
- Structural risks, including ligature points.
- Capacity risks relating to the number of residents in the approved centre.
- The process for notifying the Mental Health Commission about incidents involving residents of the approved centre.
Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

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

Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and seclusion, and at resident admission and transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. An individual risk assessment was not documented prior to one resident’s discharge. Structural risks, including ligature points, remained but were effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service.

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

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

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

### INSPECTION FINDINGS

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

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

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

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate and attached registration conditions were displayed prominently in the approved centre.

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

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

Section 59

(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
   (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
   (b) where the patient is unable to give such consent –
      (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
      (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated June 2018. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: There was a dedicated ECT suite in a specified location in the critical care area. The ECT suite had a private waiting room, an adequately equipped treatment room, and an adequately equipped recovery room. The approved centre had a facility for monitoring EEG on two channels. ECT machines were regularly maintained and serviced, and a record of maintenance was kept. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. There was a named consultant psychiatrist (CP) with overall responsibility for ECT management, and a named consultant anaesthetist with overall responsibility for anaesthesia. There was at least two registered nurses in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one patient who had received ECT since the last inspection was reviewed. The patient’s clinical file indicated that they did not have the capacity to consent. ECT was administered according to section 59(1)(b) of the Mental Health Act (MHA) 2001, as amended. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by both consultant psychiatrists for each ECT programme. A copy of the Form 16 was not sent to the Mental Health Commission (MHC) within the required timeframe. Both consultant psychiatrists assessed the patient and recorded all relevant information. The prescription for ECT was recorded in the patient’s clinical file. A cognitive assessment was completed before each programme of ECT. The patient’s clinical status was assessed before and after each ECT treatment session. The consultant psychiatrist, in consultation with patient, reviewed the patient’s progress and need for continuation of ECT.

NON-COMPLIANT

Risk Rating LOW
The approved centre was non-compliant with this rule because a copy of the Form 16 was not sent to the MHC within the required timeframe, 4.4.
Section 69: The Use of Seclusion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated October 2018. The approved centre had separate written policies in relation to the use of seclusion, the training of staff in relation to the use of seclusion, and the use of CCTV for observing residents in seclusion.

The policy addressed the following:

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

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

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

Evidence of Implementation: Seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. A number of dead flies and dust were observed in the seclusion room in Cedar Ward. This was remedied immediately. All furniture and fittings were not of a design and quality so as not to endanger patient safety. Hard and rough edged frames were observed around windows. Seclusion rooms were not used as bedrooms.

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

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

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of the seclusion episode was made by a nurse every 15 minutes, including level of distress and behaviour. A nursing review took place every two hours, during this review, at least two staff entered the seclusion room. A medical review of each patient was undertaken within four hours after the commencement of the episode of seclusion.

The seclusion initiation was recorded in a clinical file and seclusion register by the person who initiated seclusion. The seclusion register was signed by responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. The reason for ending seclusion was recorded in clinical files. A copy of the seclusion register placed in clinical file. Each episode was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days.

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

a) The seclusion facility in Cedar Ward had not been adequately cleaned as there were a number of dead flies and dust observed on the walkabout, 8.2.

b) Fittings were not of a design and quality so to ensure they were not a danger to patient safety as the window frames were hard and rough edged, 8.3.
9.0 Inspection Findings – Mental Health Act 2001

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

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

57. (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. Both patients had consented to receiving treatment. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment for each patient. The written records of consent recorded the following:

- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient which had taken place on the nature and purpose of the medications, the effects of the medications, including the risks and benefits and any views expressed by the patient, and any supports provided to the patient in making the decision to consent.

The written records of consent for one patient did not include the name of the medication(s) prescribed.
The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because the written record of consent for one patient did not include the name of the medication(s) prescribed.
10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Use of Physical Restraint

Please refer to the Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was last reviewed in October 2019. The policy included details of the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

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

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

Evidence of Implementation: Three episodes of physical restraint were inspected. Physical restraint was only used in exceptional circumstances and as a last resort, when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident’s unsafe behaviour. In all cases, the restraint order lasted for 30 minutes maximum.

Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint. Residents’ next of kin were informed about the physical restraint. The residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

Each episode of physical restraint was documented in a clinical file. A clinical practice form was completed by the initiator of physical restraint within three hours. That form was signed by a clinical psychiatrist within 24 hours and placed into the resident’s clinical file.

Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. The resident was given the opportunity to discuss the episode with members of the MDT as soon as was practicable.

The approved centre was compliant with this code of practice.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated April 2019. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: There was a dedicated ECT suite in the approved centre with a waiting room and a recovery room. The waiting room was private, the ECT suite was adequately equipped, and there was an adequately equipped recovery room.

The clinical file of one resident who had received ECT was reviewed. Procedures relating to consent and the provision of ECT were thoroughly documented.

The approved centre had a facility for monitoring EEG on two channels. ECT machines were regularly maintained and a record of maintenance was kept. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. There were up-to-date protocols for management of cardiac arrest, anaphylaxis, and malignant hyperthermia, prominently displayed. There were at least two registered nurses in the ECT suite at all times, one of whom was a designated ECT nurse.

The approved centre was compliant with this code of practice.
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 a written policy in relation to admission, transfer, and discharge. The admission policy was last reviewed in September 2017, the transfer policy was last reviewed in July 2017, and the discharge policy was last reviewed in June 2017. All policies combined included all of the policy related criteria of the code of practice.

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

Monitoring: Audits had not been completed on the implementation of and adherence to the admission, transfer or discharge policies.

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who was discharged from the approved centre was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan included a follow-up plan but did not include reference to early warning signs of relapse and risks.

A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident’s family. A pre-discharge assessment was completed, which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, it did not include a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. There was no evidence that a preliminary discharge summary was sent to the general practitioner/primary care/community mental health team within three days. There was also no evidence that a comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, and risk issues such as signs of relapse.
The approved centre was non-compliant with this code of practice for the following reasons:

a) There was no audit of the implementation of and adherence to the admission, transfer or discharge policies, 4.19.

b) The discharge assessment did not include a comprehensive risk assessment and risk management plan, 34.4.

c) There was no evidence that a preliminary discharge summary had been sent to the general practitioner/primary care/community mental health team within three days, 38.3.

d) There was no evidence that a comprehensive discharge summary was issued within 14 days, 38.3(b).

e) The discharge plan did not include a reference to early warning signs of relapse and risks, 34.2.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 28: Register of Residents

**Reason ID: 10000544**

The register of residents was not up to date, 28(1). Resident status (voluntary or involuntary) was not documented on the register, 28(2). Discharge diagnosis was not consistently documented, 28(2).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>28(1) A register of residents was created to capture status data in real-time. 28(2) A list of outstanding D/C diagnosis was drawn up by sector and given to the consultant to action within the team CD informed of non-compliance</td>
<td>28(1&amp;2) Daily patient returns are inputted onto register of residents daily, as part of daily responsibilities for admin staff 28(2) Status is recorded and maintained on the register of residents' template on a daily basis. 28(2) The consultants are emailed a request for the diagnosis of their patients for input, if not already recorded.</td>
<td>Achieved</td>
<td>03/10/2019</td>
<td>Admin, NCHD, CD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>28(1&amp;2) Alignment of the Register of Residents update with routine HRB process update - admin daily duty's Admin staff liaise with the units for confirmation of change of status. Nominated NCHD to oversee and work with administration to ensure continued compliance. Issues arising will be escalated to the</td>
<td>Register will be checked in line with HRB quarterly returns; breaches of this process will be escalated to the CD Monthly audits to assess compliance with d/c diagnosis</td>
<td>Achievable</td>
<td>24/01/2020</td>
<td>Administration, NCHD, CD</td>
<td></td>
</tr>
</tbody>
</table>
sector teams and CD if needed. Date stamp has been included on the patients 'front sheet' to capture, Primary and Secondary diagnoses. Carried out by Grade 4 admin staff.
Regulation 19 General Health

**Reason ID : 10000552**

A six monthly general health assessment was not documented for one resident, within the six-month timeframe, 19(1)(b).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This was corrected immediately at time of inspection.</td>
<td>6 monthly physical was completed</td>
<td>Achieved</td>
<td>17/07/2019</td>
<td>CD and CNM 3</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>6 monthly physicals are monitored on a weekly basis, using a tracking chart, by the CNM2 of the unit. The 6 month physical form is printed in colour and is kept by the CNM2. An alert system is in place, notifying the teams that a 6 monthly physical assessment is due 2 weeks before hand both verbally and by a sticker placed in the chart. The correct colour printed form is then addressograph and placed in the front of the chart for the NCHD to locate and complete.</td>
<td>6 monthly physicals are a standing agenda item in the CNM meetings. Delays in completion of the 6 month physicals are escalated to the CD via the CNM3 Quarterly audits on 6 monthly assessment with feedback to CD. Results discussed at the Compliance Meeting and Physical Health steering group</td>
<td>These measures are achievable and realistic.</td>
<td>05/12/2019</td>
</tr>
</tbody>
</table>

**Reason ID : 10000553**

Four six-monthly general health assessments did not document at least one of the following requirements; the residents’ BMI, weight, and waist circumference, blood pressure, smoking status, nutritional status, a medication review, or dental health, 19(1)(a).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non compliant six monthly physicals were identified by the CNM in the unit and areas of non compliance were rectified.</td>
<td>CNM checked to ensure that the 6 month physicals were completed in full.</td>
<td>Achievable</td>
<td>19/11/2019</td>
<td>CD, NCHD, CNM3</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Quarterly audits. Results and need for remediation are</td>
<td>Achievable</td>
<td>13/12/2019</td>
<td>CD, NCHD, CNM3</td>
</tr>
<tr>
<td>Physical form updated following feedback from the NCHD group, to indicate that all areas were to be completed. Sticker is placed in the chart 2 weeks before to prompt that the 6 monthly physical is due and to order bloods &amp; ECG</td>
<td>Discussed at the Compliance Meeting, CNM meeting and Consultant meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>Reason ID: 10000555</td>
<td>The Regulation 11: Visits, Regulation 12: Communication and Regulation 26: Staffing policies had not been reviewed within the recommended 3-year period.</td>
<td></td>
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</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td>Policies prioritised and reviewed and updated within the Policy group framework.</td>
<td>Policy spreadsheet with traffic light system, green in date, yellow 3 months lead to indicate that it is going out of date, red out of date. Bi monthly policy meetings when back log cleared.</td>
<td>Achieved</td>
<td>23/10/2019</td>
<td>Policy group members</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Policy schedule outlined for 2020 Policy group bi monthly meeting Progress/issues to be addressed at the compliance meeting</td>
<td>Yearly policy audit</td>
<td>Achievable</td>
<td>12/12/2019</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

#### Reason ID: 10000556

The approved centre was non-compliant with this regulation as the approved centre was not maintained in good decorative condition as the ceiling tiles in the games room were loose in two areas, a number of ceiling tiles were stained, the internal garden in Aspen ward was in a poor state of repair and some of the old flooring in the approved centre was scuffed and in need of replacement, 22(1)(a).

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Ceiling tiles replaced in games room and stained tiles replaced in ECT waiting area. Garden is maintained by outside contractor who visit fortnightly and records visit on a sign in sheet. Quotes have been sought for Aspen garden area to redesign the area.</td>
<td>Garden maintenance record Maintenance spread sheet kept and maintained by ADON</td>
<td>Achievable</td>
<td>30/05/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Flooring has been added to the project of works for 2020 Bi monthly maintenance meetings to project manage schedule of works. Schedule of works discussed at Unit Management meetings Premises policy has been drawn up to outline roles/responsibilities and procedures.</td>
<td>Project of works is discussed at the monthly Unit management meeting. Works are prioritised according to need and available funding. Works are tracked on a spreadsheet</td>
<td>Achievable</td>
<td>30/05/2020</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000557

The lighting in the games room was not sufficiently bright and positioned to facilitate reading and other activities, 22(1)(b).

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Request for works 27/7/2019 2 monthly maintenance meetings attended by post-holders</td>
<td>Achievable</td>
<td>12/12/2019</td>
<td>ADON, Tec Service Manager, Finance manager</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Bi-monthly maintenance meeting to address delays in works requested.</td>
<td>When lights have been installed</td>
<td>Achievable</td>
<td>18/12/2019</td>
</tr>
</tbody>
</table>
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

| Reason ID : 10000558 | A record of allergies or sensitivities to any medications, including if the resident had no allergies, had not been recorded for one resident, 23(2). One MPAR did not record the stop date for each discontinued medication, 23(2). Not all medications administered to residents were recorded in the MPAR. There were gaps in the administration records pertaining to two residents, 23(2). |

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Omissions re allergy status and stop date were corrected on the day of inspection. Medication administer gaps were followed up by the CNM1 to identify why the medication was not administered and reported accordingly</td>
<td>Quarterly audits</td>
<td>Achievable</td>
<td>17/07/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>New MPAR due for launch January 2020 which includes stop dates and prompts. Specific MPAR training will be given to medical and nursing staff prior to launch by the pharmacist. Routinely, the Pharmacist provides six monthly training for all doctors. Pharmacist (0.5 WTE) reviews all admitted patients' MPAR's. Nursing staff check MPAR's daily to ensure medication appropriately administered and recorded. Consultants review MPAR's at MDT meetings.</td>
<td>Quarterly MPAR audits Nursing daily checks and discrepancies are notified to nurse in charge who alerts responsible staff member.</td>
<td>Achievable</td>
<td>27/03/2020</td>
</tr>
<tr>
<td>Reason ID : 10000547</td>
<td>Code of Practice on Admission, Transfer and Discharge to and from an approved centre</td>
<td>There was no audit of the implementation of and adherence to the admission, transfer or discharge policies, 4.19.</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>Transfer audit was completed in May 2019 Admission audit was completed in Oct 2019 Discharge audit completed Nov 2019</td>
<td>Yearly audit Achieved 31/10/2019 ADON, CNM3</td>
<td></td>
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<tr>
<td><strong>Preventative Action</strong></td>
<td>An audit schedule is drawn up to allow for delegation of audits across the MDT. Audit schedule to be reviewed at each Compliance Meeting and delays to schedule identified and action plan agreed.</td>
<td>Audits to be tracked on a spreadsheet, using a traffic light system to identify audits due Achievable 29/01/2020 CNM3 CD</td>
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<table>
<thead>
<tr>
<th>Reason ID : 10000548</th>
<th>Code of Practice on Admission, Transfer and Discharge to and from an approved centre</th>
<th>The discharge assessment did not include a comprehensive risk assessment and risk management plan, 34.4. There was no evidence that a preliminary discharge summary had been sent to the general practitioner/primary care/community mental health team within three days, 38.3. There was no evidence that a comprehensive discharge summary was issued within 14 days, 38.3(b). The discharge plan did not include a reference to early warning signs of relapse and risks, 34.2.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>38.3 Discharge pathway process being comprehensively reviewed to ensure quality and compliance 38.3(b) Discharge information collated into 3 categories- Awaiting dictation, Awaiting correction, Awaiting signature List of outstanding discharge summaries sent to the consultants and CD. Agency admin staff hired to work through back log.</td>
<td>Discharge spreadsheet records the information and allows for audit Care plan audits once new document implemented. Achievable 05/11/2019 Admin staff, CD</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Spreadsheet to be updated in real time to reflect D/C summary path A D/C SOP has been drawn up to outline roles/responsibilities and time frames for the comprehensive d/c summary Non-compliances to be escalated to the CD, Admin manager Care plan document redevelopment in process to include discharge assessment/plan, comprehensive risk assessment and risk management plan and early warning signs of relapse and risks. The next phase of care plan training will include specific training on this. NCHD induction training to include education on the discharge process.</td>
<td>Monthly audits to be completed on the initial and comprehensive discharge summaries Results of this to be fed back to the compliance and QPS meetings Monthly care plan audits</td>
</tr>
</tbody>
</table>
### Rules Governing the Use of Electro-Convulsive Therapy

<table>
<thead>
<tr>
<th>Reason ID: 10000554</th>
<th>A copy of the Form 16 was not sent to the MHC within the required timeframe, 4.4.</th>
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<tbody>
<tr>
<td></td>
<td><strong>Corrective Action</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td></td>
<td>Error rectified immediately at time of inspection</td>
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<tr>
<td>Reason ID: 10000561</td>
<td>The written record of consent for one patient did not include the name of the medication(s) prescribed.</td>
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<td>---------------------</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>Corrected immediately at time of inspection&lt;br&gt;The consent was completed in full by the treating consultant&lt;br&gt;Achieved&lt;br&gt;17/07/2019&lt;br&gt;CD, patient's consultant</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>A revised Consent to treatment form has been designed to ensure compliance with Part 4 of the MHA. The Mental Health administrator will inform the Consultant when a consent to treatment is due.&lt;br&gt;The Mental Health administrator will check to ensure the consent is completed in full.&lt;br&gt;Achievable&lt;br&gt;02/11/2019&lt;br&gt;CD, Consultant group, MHA administrator</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.