# Sliabh Mis Mental Health Admission Unit, University Hospital Kerry

**ID Number:** AC0055

## 2019 Approved Centre Inspection Report (Mental Health Act 2001)

<table>
<thead>
<tr>
<th>Sliabh Mis Mental Health Admission Unit, University Hospital Kerry</th>
<th>Approved Centre Type:</th>
<th>Most Recent Registration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rathass Tralee Co Kerry</td>
<td>Acute Adult Mental Health Care</td>
<td>1 March 2017</td>
</tr>
</tbody>
</table>

## Conditions Attached:

- Yes

## Registered Proprietor:

- HSE

## Registered Proprietor Nominee:

- Mr Kevin Morrison, General Manager, Mental Health Services, Cork Kerry Community Healthcare

## Inspection Team:

- Noeleen Byrne, Lead Inspector
- Carol Brennan-Forsyth
- Sarah Moynihan
- Emma Harrington

## Inspection Date:

- 19 – 22 February 2019

## Previous Inspection Date:

- 13 – 16 February 2018

## Inspection Type:

- Unannounced Annual Inspection

## The Inspector of Mental Health Services:

- Dr Susan Finnerty MCRN009711

## Date of Publication:

- Tuesday 20 August 2019

### 2019 COMPLIANCE RATINGS

<table>
<thead>
<tr>
<th>REGULATIONS</th>
<th>RULES AND PART 4 OF THE MENTAL HEALTH</th>
<th>CODES OF PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>21</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

- **Compliant**
- **Non-compliant**
- **Not applicable**
RATINGS SUMMARY 2017 – 2019

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

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

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

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

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

Sliabh Mis was a 34-bed acute psychiatric unit located in Kerry University Hospital in Tralee in Community Healthcare Organisation (CHO) 4. It had two acute admission wards, Reask and Valentia, and one high-observation ward, Brandon, which was not in use at the time of the inspection. Multi-disciplinary teams (MDTs) from five geographical sectors referred residents to the approved centre. As well as the sector area teams, there were also residents under the care of rehabilitation and recovery and psychiatry of old age (POA) teams.

The management had agreed to reduce the number of residents to 30 for the duration of refurbishment work. The inspection team observed that there was overcapacity in Valentia and Reask wards, as an additional four beds were brought in to these wards. This resulted in the approved centre’s registered number of 34 beds being made available in two wards rather than three as per the registration.

No areas of compliance were rated excellent on this inspection. There has been a decrease in compliance with regulations, rules and codes of practice from 65% in 2018 to 58% in 2019 (the same percentage as in 2017). Non-compliance with Regulation 21: Privacy was rated as critical risk.

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; however, the approved centre was non-compliant with Regulation 15: Individual Care Plan at the time of inspection.

Condition 2: To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.
Finding on this inspection: The approved centre was not in breach of Condition 2; however, the approved centre was non-compliant with Regulation 21: Privacy and Regulation 22: Premises at the time of inspection.

Safety in the approved centre

- Ninety-eight percent of nurses were up-to-date with Prevention and Management of Violence and Aggression (PMAV) training as a result of a concerted effort to get everybody trained.
- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.
- Individual risk assessments were completed prior to episodes of physical restraint and seclusion, at resident admission and transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.
- 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.

However:

- Four of the four-bedded rooms had five beds leading to an overcapacity in bedrooms which was a clinical, corporate and health and safety risk. In addition, patient safety was compromised. Due to the overcapacity, one patient was not seen by a doctor because the patient had no bed.
- Staff were not all trained in fire safety, Basic Life Support, PMAV, and the Mental Health Act 2001.
- Ligature point risks were not minimised to the lowest practicable level.
- Medication prescription, administration and storage were not always carried out in a safe manner and had the potential to lead to medication errors and incidents.

Appropriate care and treatment of residents

- Each Individual care plan (ICP) had evidence of resident and family involvement in all ICPs reviewed. A key worker was identified in all ten ICPs inspected to ensure continuity in the implementation of residents’ ICPs. Some ICPs did not meet the requirements of Regulation 15: Individual Care Plan; however, there was an improvement since the previous inspection in 2018. An ICP champion had been established on each MDT. This person promoted best practice in developing and reviewing ICPs and ensured that the resident was involved in their care plan when practicable.

- The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ ICPs. Therapeutic activities comprised a wellness group, understanding care planning, positive mental health, and exercise groups. A weekly psychology group had been initiated and ran since the last inspection. Therapeutic services and programmes were provided in separate dedicated rooms, there was an activation area with an art room, an occupational therapy kitchen, and a television room.

However:
• Special dietary needs were regularly reviewed by a dietitian, but an evidence-based nutrition assessment tool was not used.
• Twenty-two children were admitted to the approved centre since the last inspection. Although appropriate accommodation was designated and included segregation according to age and gender, sleeping arrangements, and bathroom areas, the approved centre was an adult facility; therefore, age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. The children did not have access to age-appropriate advocacy services. One child had educational needs and did not have access to any educational services in the approved centre for adults. One child was not provided with an information booklet, and as such did not have their rights explained.

Respect for residents’ privacy, dignity and autonomy

• Visiting times were displayed and there were areas where residents could meet their visitors in private.
• Searches were carried out where necessary. The searches respected the privacy and dignity of residents.
• Seclusion was used in the approved centre. One seclusion form had not been signed by a consultant psychiatrist in accordance with the Rules Governing the Use of Seclusion. Apart from this, seclusion was used in compliance with the rules.
• There was a cleaning schedule implemented and the approved centre was clean, hygienic, and free from offensive odours. There was a programme of general maintenance, decorative maintenance, and repair of assistive equipment.
• CCTV cameras used to observe residents were incapable of recording or storing a resident’s image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident.

However:

• There were no clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. There was no CCTV signage on two corridors and in the smoking area where CCTV was monitoring residents. Residents were unaware what locations of the approved centre were being monitored by CCTV. This was rectified on inspection and clear signage was put up in areas where CCTV cameras monitored residents.
• Five beds were located in four-bedded rooms that resulted in beds being very close to the next bed. Residents were not afforded privacy, as there was not enough privacy screens.
• The disrespect for residents’ privacy and dignity was also evidenced by the fact that residents were eating their meals at the bedside, in the cramped conditions, one with no bedside table.
• Adequate arrangements had not been put in place to provide for indoor or outdoor activities. The gardens were closed off due to ongoing building works.
• Not all residents were supported to keep and use personal clothing. There was a lack of storage facilities, with residents clothing found stored in the locked store room on inspection. Residents that
occupied the additional beds had clothes stored under the bed or on the floor, as they had no wardrobe or press.

- There were only four armchairs in the sitting room for fifteen residents.
- A number of clinical files inspected were not in good order, with loose pages evident. Clinical files were not adequately secured in Valencia ward.
- In relation to a patient who was unable to consent to treatment, there was no documented evidence to indicate that the consultant psychiatrist had undertaken a capacity assessment, which would have measured the patient’s ability to consent to receiving treatment. The consultant psychiatrist did not document that the resident had no capacity to consent to treatment; instead, it was documented that the patient lacked insight. This was rectified during the inspection.
- There was poor adherence to the Code of Practice on Physical Restraint, resulting in the consultant psychiatrist not being informed of the physical restraint as soon as was practicable, a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint, the clinical practice form not being signed by a consultant psychiatrist, residents not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

**Human Rights**

There were two breaches of human rights evident in the approved centre at the time of inspection:

1. Residents’ privacy and dignity were not respected, as outlined above.
2. A patient was administered medication without his/her consent and without an assessment of capacity to consent to treatment.

**Responsiveness to residents’ needs**

- The approved centre’s menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing.
- Residents were provided with an information booklet on admission, and it included all necessary information about the approved centre. Information about medications, including potential side-effects, and diagnosis was provided to each resident or their families, where appropriate.

However:

- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during every second weekend.
- The activities timetable was not always accurate. At the time of inspection, morning gym was printed on the timetable but there was no gym available.
- The recreational activities provided by the approved centre were not appropriately resourced:
  - There was a limited supply of self-starter resources and equipment due to building works taking place in the approved centre.
Opportunities were not provided for indoor and outdoor exercise and physical activity. The garden and gym were closed off due to on-going building works.
Communal areas provided were not suitable for recreational activities. There was one sitting room for each ward which was small in size.
A bedroom was temporarily being used as a sitting room on Reask Ward. There were not enough chairs in the sitting room for the number of residents who required seats.

Governance of the approved centre

- The approved centre was represented at the CHO 4 Mental Health Management Team meeting, which was held monthly.
- Approved centre meetings were attended by the executive clinical director, consultants, nursing management staff, and nurses in the approved centre. These meetings discussed a broad range of issues, including the risk register, incidents, ICPs, audits, complaints, and smoking cessation.
- The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.
- Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.
- Incidents were risk-rated in a standardised format, and were recorded on the national incident management system.

However:

- The Quality and Patient Safety meeting was scheduled every two months. According to the minutes, the overcapacity that was evident in the approved centre was not discussed at these meetings.
- There was an absence of good governance and the management of the planned refurbishment. The dining room and garden were closed and the Brandon Unit was also closed resulting in four beds not being available. The management had agreed to reduce the number of residents to 30 for the duration of the refurbishment work; however, the inspection team observed that capacity had been increased in Valentia and Reask wards as an additional four beds were brought in to these wards. This breached the approved centre’s own policy which stated that in an emergency situation, if an extra bed was authorised it was the responsibility of the consultant who authorised it and the clinical nurse manager 2 (CNM2) to make alternative arrangements within 24 hours, i.e., the bed had to be removed. Bed occupancy figures showed that the approved centre had additional beds on 13 nights out of 14 nights prior to the inspection.
- The person with responsibility for risk management did not review incidents for trends or patterns occurring in the services in relation to the risk of overcapacity.
- The overcapacity risk was not documented in the risk register.
- There was insufficient replacement staff to release rostered staff to attend training days. This was documented as a risk on the risk register.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An individual care plan (ICP) champion had been established on each multi-disciplinary team (MDT). This person promoted best practice in developing and reviewing individual care plans and ensured that the resident was involved in their care plan when practicable.

2. A new information booklet was developed.

3. All nursing staff completed training in HSE Best Practice Guidance. The guidance is the HSE’s commitment to foster a supportive community of practice in quality and safety.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Sliabh Mis was the acute psychiatric unit for the Kerry area, Community Healthcare Organisation (CHO) 4. It was located within University Hospital Kerry, Tralee, and comprised two acute admission wards, Reask and Valentia, and one high-observation ward, Brandon, which was not in use at the time of the inspection. The approved centre was registered to accommodate 34 residents in total, 15 beds in Reask, 15 beds in Valentia and 4 in Brandon. Due to an extensive refurbishment programme and Brandon ward being closed, the number of beds had been reduced to 30; however, during the inspection it was found that there was 34 beds between Reask and Valentia wards.

Valentia and Reask wards had recently been refurbished and were bright and modern in its appearance. Brandon ward and the therapy area were in a similar condition. The dining room/sitting room, gym and garden were closed due to the refurbishment. Residents had all their meals in their bedrooms and a temporary sitting room was set up.

Multi-disciplinary teams (MDTs) from five geographical sectors referred residents to the approved centre. As well as the catchment area teams, there were also residents under the care of rehabilitation and recovery and psychiatry of old age (POA) teams. The MDT meetings took place in the approved centre on a weekly basis.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>34</td>
</tr>
<tr>
<td>Number of beds during refurbishment</td>
<td>30</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>34</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>12</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>2</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>1</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>6</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre had a system of governance and a number of meetings took place. Unit meetings were attended by the executive clinical director, consultants, nursing management staff, and nurses in the approved centre. These meetings discussed a broad range of issues, including the risk register, incidents, the individual care plan, audits, complaints, and smoking cessation.
The Quality and Patient Safety meeting was scheduled every two months. The approved centre was represented at the Mental Health Management Team, Cork Kerry Community Healthcare meetings, which were held monthly. The minutes of these meetings were made available to the inspection. According to the minutes, the overcapacity that was evident in the approved centre was not discussed at these meetings.

There was an absence of good governance and the management of the planned refurbishment. The dining room and garden were closed and the Brandon Unit was also closed resulting in four beds not being available. The management had agreed to reduce the number of residents to 30 for the duration of the refurbishment work. The inspection team observed that capacity had been increased in Valentia and Reask wards as an additional four beds were brought in to these wards. This resulted in the approved centres registered number of 34 beds being made available in two wards rather than three as per the registration. Five beds were located in four-bedded rooms that resulted in beds being very close to the next bed. Residents were not afforded privacy, as there was not enough privacy screens. There was insufficient wardrobes for residents to hang clothes with some placing their clothing on the floor and under the beds. There was also two beds placed in a single room. On one night, a resident had to sleep on two chairs due to the overcrowding.

This breached the approved centre’s own policy which stated that in an emergency situation, if an extra bed was authorised it was the responsibility of the consultant who authorised it and the clinical nurse manager 2 (CNM2), to make alternative arrangements within 24 hours, i.e., the bed had to be removed. Bed occupancy figures showed that the approved centre had additional beds on thirteen nights out of fourteen nights prior to the inspection.

The affront to residents’ privacy and dignity was also evidenced by the fact that residents were eating their meals at the bedside, in the cramped conditions, one with no bedside table. Adequate arrangements had not been put in place to provide for indoor or outdoor activities. The garden and the gym were closed off due to ongoing building works.

It was the responsibility of Kerry MHS Management Team to oversee the process to ensure that policy and procedures were adhered to and actions communicated to manage risks were responded to and escalated as appropriate. Risks relating to issues as documented above and fire doors being held open by linen were not documented on the risk register and the proper escalation processes were not followed. Fire safety training had only been completed by 41% of nursing staff.

There was insufficient replacement staff to release rostered staff to attend training days. This was documented as a risk. Of note, 98% of nurses were up-to-date with Prevention and Management of Violence and Aggression (PMAV) training as a result of a concerted effort to get everybody trained.

There was 22 child admissions to the approved centre, since the last inspection. Of the 22, only 3 children were transferred to a Child and Adolescent Mental Health Service (CAMHS). One of the reasons offered was that there was a shortage of CAMHS Consultants Psychiatrists. The duration of stay of children ranged from 1 to 181 days with 10 children resident for more than two weeks at various times since the last inspection. Every effort was made to accommodate these children in single rooms with a chaperone and provide a safe environment for the duration of their treatment.
3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>Critical</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>X</td>
<td>Moderate</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>High</td>
<td>Critical</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Critical</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>X</td>
<td>High</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>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Code of Practice Relating to the Admission of Children under the Mental Health Act 2001</td>
<td>X</td>
<td>High</td>
<td>Moderate</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>Moderate</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

No areas of compliance were rated excellent on this inspection.
### 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>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of 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 on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

Eight residents met with the inspectors and provided feedback on their experience since admission to the approved centre. Most residents expressed satisfaction regarding the quality of care and support they received from staff. Many were very complimentary of the nursing staff. Residents were aware that the impact of the refurbishment was that there was limited space. In particular, there was no garden and the only outdoor space was the smoking area. Physical exercise was also limited as the gym was closed and going for a walk was the only real option.

Residents commented that there was not enough seats in the sitting room. Residents ate their meals in the bedrooms as the dining room was closed. Some residents reported having to eat their meal on their lap, as there was no bed table. Residents said that there was an extra bed added to the room and this meant they had no locker or wardrobe to put clothes and other items in. Some described the rooms as being cramped and that they were squashed in.

Despite the lack of space, residents stated that there were therapeutic groups running every day. MDTs met weekly with residents invited to attend and to engage in the development of their individual care plan. Residents said that the team listened to them and they could have a copy of their care plan if they wished.

Nine completed resident questionnaires were returned to the inspectors. Six indicated that the residents understood their care plan and all knew who their key worker was. Four indicated that they did not have space for privacy and comments suggested this was attributable to the cramped conditions. Three of the nine felt that there was not enough activities during the day. On a scale of 1-10, with 1 being poor and 10
being excellent, two residents rated between 1 and 3, for overall experience of care and treatment, five rated between 4 and 7 and two rated between 8 and 10.

The Irish Advocacy Network (IAN) representative visited the approved centre weekly. There was a notice naming the IAN contact and details. The inspector spoke with the IAN representative to discuss issues and positive aspects as reported by residents. It was reported that staff were friendly, helpful, and supportive and the food was very good. Issues brought to the IAN representative were largely around the lack of facilities due to the refurbishment and they were aware that they were scheduled to re-open in the coming weeks.
6.0 Feedback Meeting

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

- Acting Clinical Director
- Principal Social Worker
- Area Director of Nursing acting for Registered Proprietor
- Head Occupational Therapist
- Assistant Director of Nursing
- Interim Area Administrator
- Clinical Nurse Manager 2
- Acting Clinical Nurse Manager 2
- Acting Senior Social Worker
- Mental Health Administrator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The Area Director of Nursing stated that there was an updated version of the staff training document and agreed to submit it to the MHC before the close of business on Tuesday 26th February 2019.
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 July 2017. The policy included all of the requirements of the Judgement Support Framework.

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

**Monitoring:** An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification process.

**Evidence of Implementation:** A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The identifiers, detailed in residents’ clinical files, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre used the name, medical record number, and date of birth of each resident as identifiers. The identifiers used were person-specific and appropriate to the residents’ communication abilities, and did not include room number. There was a sticker alert system in place on clinical files, to assist staff in telling the difference between residents with the same or a similar name.

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

<table>
<thead>
<tr>
<th>COMPLIANT</th>
<th>Quality Rating</th>
<th>Satisfactory</th>
</tr>
</thead>
</table>

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

#### INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** The approved centre’s menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs. Residents were provided with a hot meal daily and a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Hot and cold drinks were offered to residents regularly. In relation to residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. Their special dietary needs were regularly reviewed by a dietician, but an evidence-based nutrition assessment tool was not used.

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene 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: At the time of the inspection, the main kitchenette and residents’ dining area were being renovated in Reask Ward. As a temporary measure, the approved centre was using the kitchenette in Brandon Suite until renovation works were completed. There was suitable and sufficient catering equipment in the approved centre.

There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Residents were eating meals by their bedside at the time of the inspection, while renovation works were taking place in the dining room. 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 monitoring pillar.
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

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

Not all residents were supported to keep and use personal clothing. There was a lack of storage facilities, with residents clothing found stored in the locked store room on inspection. Residents that occupied the additional beds had clothes stored under the bed or on the floor, as they had no wardrobe or press.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The communications with residents and their representatives regarding residents’ entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.
- 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. Relevant staff were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

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

Evidence of Implementation: Secure facilities such as safes were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis, in line with the approved centre’s policy.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff and the resident or their representative.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes pillar.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities. The policy had no approval date or revision date. 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 not maintained of the occurrence of planned recreational activities, including a log of resident 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 every second weekend. The activities timetable displayed to residents, detailed accessible and user-friendly information on recreational activities, including the type and frequency of recreational activities. The activities timetable was not however, always accurate. At the inspection time, morning gym was printed on the timetable but there was no gym available at the time of the inspection.

The recreational activities provided by the approved centre were not appropriately resourced. There was a limited supply of self-starter resources and equipment due to building works taking place in the approved centre. Opportunities were not provided for indoor and outdoor exercise and physical activity. The garden and gym were closed off due to on-going building works. Communal areas provided were not suitable for recreational activities. There was one sitting room for each ward which was small in size. A bedroom was temporarily being used as a sitting room on Reask Ward. There were not enough chairs in the sitting room for the number of residents who required seats.

Documented records of attendance were retained for recreational activities in-group records or within the resident’s clinical file, as appropriate.

The approved centre was non-compliant with this regulation because the registered proprietor did not provide in so far as was practicable, access for residents appropriate recreational activities.
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. The policy was last reviewed in July 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The implementation of the policy to support residents’ religious practices was 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 multi-faith chaplains. Mass was held once a week. There were facilities available to support residents’ religious practices including a Church within the premises of the main hospital. There was a pastoral care group available to residents once a week on the unit. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the 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 in relation to visits. The policy was last reviewed in July 2017. The policy included the requirements all of the Judgement Support Framework.

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

Monitoring: Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed, and were also detailed within the resident information booklet. Visiting times were appropriate, reasonable, and flexible where necessary. A separate visitor room and visiting areas were 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. Due to renovation work at the time of the inspection a small interview room was being used as the visitors’ room. Visits could also be facilitated in an activation room, TV room and outside of the unit in a coffee area.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room and facilities available were suitable for visiting children, but there were no children’s’ books or toys available in the room.

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 12: Communication

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: 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, fax, the Internet including e-mail, and the telephone. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. The Clinical Director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Training and Education: There was no signature log available to inspectors to indicate whether or not relevant staff 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 was not systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had been completed to identify opportunities for improvement of search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The clinical file of one resident who was searched was inspected. The resident’s consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during a search.
and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

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

General written consent was not sought for routine environmental searches. A written record was not kept of all environmental searches.

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, monitoring, and evidence of implementation pillars.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Systems analysis was undertaken in the event of a sudden or unexplained death in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: No resident had died in expected circumstances since the last inspection. One sudden death, which occurred in the approved centre since the last inspection, was reviewed. Legal requirements in relation to the sudden death were followed. The sudden death of the resident was managed in accordance with the resident’s religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends.

Family members were contacted. This death was reported to the Mental Health Commission within the required 48-hour timeframe. There was no evidence to indicate that support was given to residents and staff following the resident’s death.

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 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 July 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The ICPs of ten residents were inspected. Each ICP was a composite set of documents stored in the clinical file. Each resident was assessed at admission and an initial care plan was completed by the admitting clinician to address the immediate needs of the resident. A key worker was identified in all ten ICPs inspected to ensure continuity in the implementation of residents’ ICPs. There was evidence of resident involvement in all ICPs. All ICPs were drawn up with the family’s involvement. The ten ICPs inspected included an individual risk management plan.

In all ICPs reviewed, an ICP was developed within seven days of admission; however, in one ICP, the ICP had not been developed by the full MDT. In one ICP, there was no evidence to indicate that the resident was offered a copy of their ICP. In one ICP whether the resident declined or refused a copy of their ICP was not recorded, the explanation for the decline if given was not recorded. One ICP did not contain specific and appropriately defined goals for the resident. Three ICPs did not include a preliminary discharge plan.

Residents had access to their ICPs and were kept informed of any changes.

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

a) One ICP had not been developed by the MDT.
b) One of the ten ICPs inspected did not contain specific and appropriately defined goals for the resident.
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 therapeutic services and programmes, dated July 2017. The policy included requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- Assessing residents as to the appropriateness of services and programmes (including risk).
- The review and evaluation of therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.
- The provision of therapeutic services and programmes by external providers in external locations.

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

Monitoring: There was evidence of ongoing monitoring of the range of therapeutic services and programmes provided to ensure that they met the assessed needs of residents. A documented analysis was not completed to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: A list of therapeutic services and programmes provided within the approved centre was available to residents through a timetable of activities, which was publically displayed on the unit. The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans.

All therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Adequate resources and facilities were available. Therapeutic activities comprised a wellness group, understanding care planning, positive mental health, and exercise groups. A weekly psychology group had been initiated and ran since the last inspection.

Therapeutic services and programmes were provided in separate dedicated rooms, there was an activation area with an art room, an occupational therapy kitchen, and a television room. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents clinical files.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.
Regulation 17: Children’s Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

INSPECTION FINDINGS

Processes: There was a written policy dated July 2017, in relation to the provision of education to child residents in the approved centre. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The information provided to child residents and their representatives on available educational services.
- The methods for assessing child residents’ progress within the educational provisions of the approved centre.
- The management of the transition of child residents between educational services.

Training and Education: Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs. All relevant staff had completed Children First training.

Monitoring: A daily record was not kept of attendance at internal and external educational services.

Evidence of Implementation: Appropriate facilities were not available for the provision of education to child residents in the approved centre. The approved centre was an adult facility and there were no child specific facilities such as designated classrooms, tutors, and resources available. The approved centre did not provide any educational services.

Child residents were assessed regarding their individual educational requirements with consideration of their individual needs and age on admission. Sufficient personnel and resources were provided by the approved centre specifically in relation to supporting child residents in accessing external education services.

Sufficient personnel resources were not provided to educate child residents in the approved centre, there was no tutor. The approved centre did not maintain comprehensive records of each resident’s educational history, such as schools attended, reports obtained, certificates awarded, assessment reports received, and any remedial assistance provided.

Attendance by child residents at the approved centre’s educational services was not documented, including reasons for non-attendance because the approved centre did not provide educational services.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all children were provided with appropriate educational services as indicated in their individual care plans.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy May 2017, in relation to the transfer of residents. The policy detailed all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on transfers. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy. A log of transfers was maintained.

Monitoring: Each transfer record was not systematically reviewed to ensure that all relevant information was provided to the receiving facility. A documented analysis was not completed to identify opportunities to improve the transfer processes.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was inspected. Documented consent of the resident to transfer was available. The resident was risk assessed prior to transfer. All relevant information regarding the resident transferred was provided to the receiving facility.

The clinical file recorded the documentation sent to the receiving facility as part of the transfer, including the letter of referral, a list of current medications, and the transfer form. A copy of this documentation was retained in the resident’s clinical file. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility.

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.
Regulation 19: General Health

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures for responding to medical emergencies and in relation to general health, which was last reviewed in December 2017. The policy included the requirements of the Judgement Support Framework, with the exception of the following:

- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The referral process for residents’ general health needs.

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

Monitoring: Resident take-up of national screening programmes was recorded and monitored. A systematic review was undertaken to ensure six-monthly reviews of general health needs occurred. Analysis was not completed to identify opportunities to improve 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 for the purpose of responding to medical emergencies. Residents received appropriate general health care interventions in line with their individual care plans.

Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, but not less than every six months. One resident was in the approved centre for greater than six months and had received a fully completed and documented six-monthly general health assessment, including a physical examination within the appropriate timeframe.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Full records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.

For residents on antipsychotic medication, they received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels. Information was provided to residents regarding the national screening programmes by the approved centre, and residents had access to relevant national...
screening programmes. Smoking cessation and supports were offered to residents but a lot of residents were smoking in the smoking shelter at the time of the inspection.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.
Regulation 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: There was a written operational policy, dated July 2017, and procedures available in relation to the provision of information to residents. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read the policy on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as described in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis. A documented analysis was not completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents were provided with an information booklet on admission, and it included all necessary information on housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents’ rights. There were numerous copies of the booklet available on the unit for residents and visitors to access freely. Residents were provided with details of their multi-disciplinary team.

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident or their families, where appropriate. Verbal information and medication information sheets were provided to residents or their families.

Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. Medication information sheets, as well as verbal information, was provided in a format that is appropriate to the resident’s needs.
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 staff training and education, and monitoring pillars.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2017. The policy addressed the requirements of the Judgement Support Framework with the exception of the approved centre’s process for addressing a situation where resident privacy and dignity was not respected by staff.

Training and Education: 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 facilitated to make and receive private phone calls. The general demeanour of staff and the way in which staff interacted with residents was respectful. Residents wore clothes which respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. All of these locks had an override function.

Where a resident shared a room the bed screening was inadequate and their privacy was compromised. Four of the four-bedded rooms were accommodating five residents each. Three of these rooms did not have a privacy screen between two of the residents.

Noticeboards did not display resident names or other identifiable information.

The approved centre was non-compliant with this regulation because three of the four-bedded rooms did not have a privacy screen between two of the residents, which compromised residents’ privacy and dignity.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in December 2017. The policy included the requirements of the Judgement Support Framework with the exception of the approved centre’s utility controls and requirements.

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

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

Evidence of Implementation: The approved centre was adequately heated and ventilated. Appropriate signage and sensory aids were provided to support resident orientation needs. There was a cleaning schedule implemented and the approved centre was clean, hygienic, and free from offensive odours. There was a programme of general maintenance, decorative maintenance, and repair of assistive equipment. Records were maintained.

Residents did not have access to sufficient personal space to move about in, including outdoor space. The approved centre was being renovated at the time of the inspection and there was limited space overall for residents to move about in. While the dining room and the kitchenette were being renovated, residents ate their meals at their bedsides. Residents had no access to the garden space during renovations. Residents in Reask had limited access to a temporary small sitting room. There were only four armchairs in that sitting room for 15 residents. Hazards were minimised. Ligature point risks were not minimised to the lowest practicable level.
Resident bedrooms were not appropriately sized to address resident needs. Four of the four-bedded rooms had five beds which left a deficit in personal space to residents. Due to this issue, residents had inadequate wardrobe space and impeded access to their wardrobes, which did not support residents’ independence and comfort.

Appropriately, sized communal rooms were not provided. Due to the overcrowding in the four-bedded rooms, not all residents had access to a bedside light. Heating could not be safely controlled in the resident’s own room. Instead, heating in Valentia and Reask Wards was controlled centrally by the maintenance department. The approved centre did not have a designated laundry room.

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

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

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

b) The registered proprietor did not ensure that the environment was maintained with due regard to the specific needs of residents as sufficient personal space was not provided, 22 (3).

c) Ligature points were not minimised 22 (3).

d) Residents did not have access to outside space 22 (3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

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

Training and Education: Not all pharmacy or medical 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. Not all nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

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

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of dosage, and frequency of medication. With the exception of one MPAR the Medical Council Registration Number of medical practitioner prescribing medication to the resident was documented.

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. One MPAR abbreviated micrograms and did not write it in full. In two MPARs, a record of all medications to the resident had not been maintained; omissions were evident. Two MPARs did not record allergy status or sensitivities to any medications, including if the resident had no allergies. The generic name of the medication, and preparation were not recorded on all MPARs.
The signature of the medical practitioner or nurse prescriber for each entry was not recorded on all MPARs. One MPAR did not record the date of discontinuation for each medication. The medication trolley and medication administration cupboard did not remain 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 monthly 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 because they did not have suitable practices relating to the prescription and administration of medications:

a) One MPAR did not have the Doctors Medical Council Registration Number (MCRN) documented on the MPAR, 23(1).

b) Two MPARs did not record the stop date for each medication, 23(1).

c) In two MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident, 23(1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: There was a written policy in place, dated July 2017, in relation to the health and safety of residents, staff and visitors. There was also an associated site-specific safety statement in place. The policy and safety statement included requirements of the Judgement Support Framework, with the exception of the following:

- First aid response requirements.
- Falls prevention initiatives.
- Vehicle controls.
- The staff training requirements in relation to health and safety.
- Infection control measures concerning:
  - Safe handling and disposal of health care risk waste.
  - Management of spillages.
  - Raising awareness of residents and their visitors to infection control measures.
  - Hand washing, linen washing, and the covering of cuts and abrasions.
  - Covering of cuts and abrasions
  - The management and reporting of an infection outbreak.
  - Specific infection control measures in relation to C. difficile, and Norovirus.
  - Availability of staff vaccinations and immunisations.
  - Management and reporting of an infection outbreak.

Training and Education: Not all staff had signed a log to indicate that they read and understood the health and safety policy. Not all staff interviewed could 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: This regulation is only assessed against the approved centre’s written policies and procedures. Health and safety practices 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, which was last reviewed in August 2017. The policy included the requirements of the Judgement Support Framework with the exception of the process to cease monitoring a resident using CCTV in certain circumstances.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all relevant 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 not clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. There was no CCTV signage on two corridors and in the smoking area where CCTV was monitoring residents. Residents were unaware what locations of the approved centre were being monitored by CCTV. This was rectified on inspection and clear signage was put up in areas where CCTV cameras monitored residents.

CCTV cameras used to observe residents were incapable of recording or storing a resident’s image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre’s use of CCTV.
The approved centre was non-compliant with this regulation because there were no clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV was not clearly labelled, 25 (1)(b).
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 two written policies and procedures in relation to its staffing requirements. The staffing policy was last reviewed in August 2017. The policies combined included the requirements of the *Judgement Support Framework*, with the following exceptions:

- The job description requirements.
- The use of agency staff.
- The process for transferring responsibility from one staff member to another.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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 relating to staffing, as set out in the policy.

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

Evidence of Implementation: Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

The number and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was not available within the approved centre. Staff were trained in manual handling, infection control and prevention, risk management and treatment, incident reporting, and recovery-centred approaches to
mental health care and treatment. Staff were trained in the protection of children and vulnerable adults, and in Children First.

There was not an organisational chart in place to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Not all health care staff were trained in the following:

- fire safety
- Basic Life Support
- The Professional Management of Violence and Aggression, (PMAV)
- The Mental Health Act 2001

<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 (48)</td>
<td>32</td>
<td>66%</td>
<td>20</td>
<td>41%</td>
<td>47</td>
</tr>
<tr>
<td>Consultant Psychiatrist (10)</td>
<td>7</td>
<td>70%</td>
<td>1</td>
<td>10%</td>
<td>5</td>
</tr>
<tr>
<td>Medical (N/A)</td>
<td>4</td>
<td>31%</td>
<td>2</td>
<td>15%</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist (9)</td>
<td>9</td>
<td>100%</td>
<td>3</td>
<td>33%</td>
<td>8</td>
</tr>
<tr>
<td>Social Worker (12)</td>
<td>7</td>
<td>58%</td>
<td>9</td>
<td>75%</td>
<td>7</td>
</tr>
<tr>
<td>Psychologist (6)</td>
<td>1</td>
<td>16%</td>
<td>1</td>
<td>16%</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care worker (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Peer support worker (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
</tbody>
</table>

Staff training was documented with the exception of medical staff and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reask ward</td>
<td>CNM2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>
The approved centre was non-compliant with this regulation for the following reasons:

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, or PMAV, 26(4).
b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valentia</td>
<td>Acting CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Both wards</td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Nurse Specialist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Night Supervisor</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in June 2017. The policy included the requirements of the Judgement Support Framework including the following:

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

The policy did not address the following:

- The required content for each resident record.
- Record review requirements.

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

Monitoring: All resident records were audited to ensure their completeness, accuracy, and ease of retrieval. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use. Resident records were reflective of the residents’ status at the time of inspection and the care and treatment being provided.

Resident records were physically stored together. Resident records were maintained using an identifier, which was unique to the resident. Only authorised staff made entries in residents’ records. Hand-written records were legible, written in black indelible ink, and were readable when photocopied. The nurses’
A desk in Valentia Ward had a cupboard behind it with a roller blind; confidential resident information was stored here. Records were not secure, as staff did not have access to a key to lock the cupboard.

A number of clinical files inspected were not maintained appropriately and were not in good order, with loose pages evident. A press with a roller blind, in Valentia ward contained resident information and could not be locked. This resulted in records not being secure. Not all residents’ records included the date, and time for each entry. The approved centre did not maintain a record of all signatures used in the resident record.

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) A number of clinical files had loose pages, 27 (1).
b) Not all residents’ records included the date, and time for each entry, 27 (1).
c) Records were not secure in Valentia Ward, 27 (1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented and up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to the Mental Health Act 2001.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated July 2017, in relation to the development, management, and review of operating policies and procedures. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on developing and reviewing operating policy. Not all relevant staff were trained on approved operational policies and procedures. Relevant staff interviewed were able to 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 of operating policies and procedures was not conducted to identify opportunities to improve the processes for developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff, and with service users’ involvement. Approved centre specific policies were developed by the local policy and procedure group. The CHO policies were developed by the Cork/Kerry Policy Group. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice and clinical guidelines. The policy for Regulation 9 was not properly approved in that it was not dated and there was no review date.

Policies were communicated to all relevant staff. Where generic policies were used, the approved centre had a written statement to this effect (adopting the generic policy), which was reviewed at least every three years. Any generic policies used were appropriate to the approved centre and the resident group profile. All operating policies and procedures required by the regulations were reviewed within three years.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring and evidence of implementation pillars.
Regulation 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 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 with a dedicated tribunal room, and adequate resources to support the Mental Health Tribunals process. A Mental Health Act Administrator was employed by the approved centre to support the Mental Health Tribunal process. Staff accompanied and assisted patients to attend their Mental Health Tribunal as required.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in place, dated July 2017, in relation to the approved centre’s complaints procedures. The approved centre also adopted the HSE’s Your Service, Your Say policy and procedures. The policies, combined, included all of the requirements of the Judgement Support Framework. The process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, the approved centre, was detailed in the policies.

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

Monitoring: There was no documented evidence that audits of the complaints log were completed. Complaints data had been analysed for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure and nominated person’s contact details were well publicised and accessible to residents, their representatives, and families in the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s ICP. 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.
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 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in December 2017. The policy addressed the requirements of the Judgement Support Framework, with the exception of health and safety risks in relation to visitors.

Training and Education: Relevant staff had not 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 not trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. Not all staff interviewed were able to articulate the risk management processes, as set out in the policy. Not 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. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Individual risk assessments were completed prior to episodes of 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. Structural risks, including ligature points, were not 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, and were recorded on the national incident management system.

Risk management procedures did not actively reduce identified risks to the lowest level of risk, as was reasonably practicable. As documented under Regulation 22 Premises, and Regulation 21 Privacy, four of the four-bedded rooms had five beds. In relation to risk this lead to an over capacity in bedrooms which was a clinical, corporate and health and safety risk. In addition, patient safety was compromised. Due to the overcapacity, one patient was not seen by a doctor because the patient had no bed. This over capacity risk was not documented in the risk register.

The approved centre did not implement a plan to reduce the risks to residents while building works were ongoing at the time of the inspection. The person with responsibility for risk management did not review incidents for trends or patterns occurring in the services in relation to the risk of overcapacity. The policy regarding authorising an extra emergency bed, stated that the Consultant and the Clinical Nurse Manager should make alternative arrangements within 24 hours. This has not been arranged.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. 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 non-compliant with this regulation because the registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, 32 (1).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

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

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

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The policy addressed who may implement seclusion, and the provision of information to the resident. The policy did not include ways of reducing rates of seclusion use.

Training and Education: The approved centre maintained a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy.

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

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file.

Three seclusion episodes and associated documentation were inspected. In all episodes, seclusion was only implemented in the resident’s best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion on all occasions.

All episodes of seclusion were recorded in the resident’s clinical file and all uses of seclusion were recorded in the seclusion register, but in one episode of seclusion, the seclusion register was not signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident’s clinical file and available to inspectors.

The approved centre was non-compliant with this regulation for the following reasons:
a) In one episode of seclusion, the seclusion register was not signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours, 3.5.

b) The seclusion policy did not include ways of reducing rates of seclusion use, 10.2 (a).
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. One patient consented to receiving treatment and the other patient did not consent.

Patient who consented to receiving treatment:

In relation to the patient who did consent to receiving treatment there was a written record of consent which detailed:

- The consultant psychiatrist had undertaken a capacity assessment, which measured the patients’ ability to consent to receiving treatment. Following the capacity assessment, this patient was deemed able to consent to receiving treatment.
- The names of the medications prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
Details of discussions with the patient, including:

- The nature and purpose of the medication(s).
- The effects of the medication(s), including any risks and benefits.

**Patient unable to consent to treatment:**

In relation to the patient who was unable to consent to treatment, a *Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* had been inadequately completed.

The form 17 detailed the names of the medication prescribed, approval by a consultant psychiatrist, authorisation by a second consultant psychiatrist, and that the patient refused a discussion on their continued treatment.

The form 17 did not detail confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications. There was no documented evidence to indicate that the consultant psychiatrist had undertaken a capacity assessment, which would have measured the patients’ ability to consent to receiving treatment. The consultant psychiatrist did not document that the resident had no capacity to consent to treatment, instead it was documented that the patient lacked insight. This was rectified during the inspection.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because there was no documented evidence to indicate that the consultant psychiatrist had undertaken a capacity assessment.
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

NON-COMPLIANT
Risk Rating HIGH

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 reviewed annually, and it was last reviewed in November 2018. The policy addressed the following:

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

Training and Education: Not all staff had signed a log to indicate that they had read and understood the physical restraint policy.

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

Evidence of Implementation: Three physical restraint episodes in relation to three residents were inspected. Physical restraint was only used in rare and exceptional circumstances 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 a maximum of 10 minutes. Each episode of physical restraint was recorded in the clinical file.

The following discrepancies were found on inspection:

- In two of the episodes of physical restraint reviewed, it was not recorded in the clinical file if the consultant psychiatrist had been informed of the physical restraint as soon as was practicable.
- In one of the episodes of physical restraint reviewed, a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint.
- In two of the episodes of physical restraint reviewed, the clinical practice form had not been signed by a consultant psychiatrist.
- In two physical restraint episodes, residents were not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was not documented in either case.
- In one episode of physical restraint the resident’s next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in one case.
- In two episodes of physical restraint, the clinical practice form was not placed in the resident’s clinical file.
- In one physical restraint episode, there was no documented record to indicate that the episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode.
The approved centre was non-compliant with this code of practice for the following reasons:

a) The approved centre did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy, 9.2 (b).

b) In two of the episodes of physical restraint reviewed, it was not recorded in the clinical file if the consultant psychiatrist had been informed of the physical restraint as soon as was practicable, 5.3.

c) In one of the episodes of physical restraint reviewed, a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint, 5.4.

d) In two of the episodes of physical restraint reviewed, the clinical practice form had not been signed by a consultant psychiatrist, 5.7 (c).

e) In two physical restraint episodes, residents were not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was not documented in either case, 5.8.

f) In one episode of physical restraint, the resident’s next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in one case, 5.9 (a).

g) In two episodes of physical restraint, the clinical practice form was not placed in the resident’s clinical file, 8.3.

h) In one physical restraint episode, there was no documented record to indicate that the episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode, 9.3.
Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had policies and protocols in place in relation to the admission of a child. The approved centre had a policy requiring each child to be individually risk assessed. A policy and procedures were in place with regard to family liaison, parental consent, and confidentiality. Procedures were in place for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in the Children First guidelines.

Evidence of Implementation: Twenty-two children were admitted to the approved centre since the last inspection. The inspection team reviewed four clinical files. The approved centre was an adult facility, therefore age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of the children and to respond to the children’s’ particular needs. The children did not have access to age-appropriate advocacy services.

In relation to consent to treatment, four clinical files were inspected against, and in one case, there was no documented form and evidence to indicate whether consent for treatment was obtained from at least one parent.

In relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated and included segregation according to age and gender, sleeping arrangements, and bathroom areas. Staff were gender sensitive.

One child had educational needs and did not have access to any educational services in the approved centre for adults. One child was not provided with an information booklet, and as such did not have their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical file did not record this child’s understanding of the explanation given because no explanation was given to them.

Appropriate visiting times for families, including children, were available. The Mental Health Commission was notified of all children admitted to approved centres for adults within 72 hours using the appropriate notification form.

The approved centre was non-compliant with this code of practice for the following reasons:
a) Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).
b) The children did not have access to age-appropriate advocacy services, 2.5 (g).
c) One child did not have their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical file did not record this child’s understanding of the explanation given because no explanation was given to them. 2.5, (h).
d) In one case, there was no documented form and evidence to indicate whether consent for treatment was obtained from at least one parent, 3.2.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in August 2017, the transfer policy was last reviewed in May 2017, and the discharge policy was last reviewed in July 2017. The policies combined included the policy related criteria of the code of practice with the following exceptions:

- The admission policy did not include reference to pre-admission assessments and reference to admission referral letters.
- The discharge policy did not include procedures for managing discharge against medical advice.

Training and Education: Not all 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, and discharge policies.

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan documented the estimated date of discharge and all other aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team (MDT) 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, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate MDT input into discharge planning. A preliminary discharge summary was issued to primary care within three days. A comprehensive discharge summary was issued within 14 days to relevant personnel. The discharge summaries included details of diagnosis, prognosis, medication, mental
state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

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

a) The admission policy did not include reference to pre-admission assessments and reference to admission referral letters, 4.3.

b) The discharge policy did not include procedures for managing discharge against medical advice, 4.15.

c) Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.

d) Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies, 4.19.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 9: Recreational Activities

**Reason ID: 10000139**

The registered proprietor did not provide in so far as was practicable, access for residents appropriate recreational activities.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Refurbishment of Valentia Ward complete. All bedrooms functional. 2 good sized sitting rooms with adequate seating functional. Gym and outdoor areas will be functioning from August 2019</td>
<td>Refurbishment of Valentia Ward complete. All bedrooms functional. 2 good sized sitting rooms with adequate seating functional. Gym and outdoor areas will be functioning from August 2019</td>
<td>Achievable</td>
<td>30/08/2019</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Refurbishment of Valentia Ward complete. All bedrooms functional. 2 good sized sitting rooms with adequate seating functional. Gym and outdoor areas will be functioning from August 2019 | Refurbishment of Valentia Ward complete. | Achievable | 30/08/2019 | Executive Clinical Director |
### Regulation 15: Individual Care Plan

#### Reason ID: 10000140

One ICP had not been developed by the MDT.

<table>
<thead>
<tr>
<th>Reason ID: 10000140</th>
<th>One ICP had not been developed by the MDT.</th>
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</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Feedback to RCPs re need for ICP development to be by MDT</td>
</tr>
</tbody>
</table>

**Preventative Action**

- Taining for Care Plan Champions has been arranged for September 2019. Monthly ICP audit to continue.
- Achievable | 31/10/2019 | Heads of Discipline

#### Reason ID: 10000141

One of the ten ICPs inspected did not contain specific and appropriately defined goals for the resident.

<table>
<thead>
<tr>
<th>Reason ID: 10000141</th>
<th>One of the ten ICPs inspected did not contain specific and appropriately defined goals for the resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Feedback to all Care Plan Champions and MDTs re need for goals to be specific and appropriate.</td>
</tr>
</tbody>
</table>

**Preventative Action**

- Change to working of compliance committee. 3 person Mini inspection teams developed one of whom will be 'inspecting' compliance with Reg 15 as part of their assigned regulations to inspect. Ongoing Through ongoing audits and inspections | Achievable | 31/10/2019 | Heads of Discipline

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| monthly ICP audit. ICP Champions Training has been arranged for end of September 2019 |   |   |   |
### Regulation 17: Children’s Education

<table>
<thead>
<tr>
<th>Reason ID : 10000142</th>
<th>The registered proprietor did not ensure that all children were provided with appropriate educational services as indicated in their individual care plans.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS team to draft guidelines for ICP items for under 18yo to include educational services for all &lt;16yo and 16-18year olds where need exists. Same to be developed via CAMHS governance committee.</td>
<td>ICP Audit on all child admissions</td>
<td>Achievable</td>
<td>01/10/2019</td>
<td>Heads of Discipline</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
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</thead>
<tbody>
<tr>
<td>CAMHS team to draft guidelines for ICP items for under 18yo to include educational services for all &lt;16yo and 16-18year olds where need exists. Same to be developed via CAMHS governance committee.</td>
<td>ICP Audit on all child admissions</td>
<td>Achievable, for discussion at the next CAMHS Governance Committee meeting</td>
<td>01/10/2019</td>
<td>Executive Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>
**Regulation 21: Privacy**

**Reason ID : 10000143**

Three of the four-bedded rooms did not have a privacy screen between two of the residents, which compromised residents’ privacy and dignity.

<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>Refurbishment of Valentia ward completed with sufficient personal space now available. Dining room opened. Ligature points minimised in newly refurbished ward.</td>
<td>Through audits of adequacy of premises</td>
<td>Achievable</td>
<td>01/08/2019</td>
</tr>
</tbody>
</table>

<p>| Preventative Action | Audits of premises | Through audits of adequacy of premises | Achievable | 31/08/2019 | Executive Clinical Director |</p>
<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Description</th>
<th>Corrective Action</th>
<th>Preventative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000144</td>
<td>It did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22 (2).</td>
<td>Refurbishment of Valentia ward completed with sufficient personal space now available. Dining room opened. Ligature points minimised in newly refurbished ward.</td>
<td>Premises Audit - Achieved 01/07/2019 Executive Clinical Director</td>
</tr>
<tr>
<td>10000145</td>
<td>The registered proprietor did not ensure that the environment was maintained with due regard to the specific needs of residents as sufficient personal space was not provided, 22 (3).</td>
<td>Refurbishment of Valentia ward completed with sufficient personal space now available. Dining room opened. Ligature points minimised in newly refurbished ward.</td>
<td>Premises Audits - Achieved 01/07/2019 Executive Clinical Director</td>
</tr>
<tr>
<td>10000146</td>
<td>Ligature points were not minimised 22 (3).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
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</tr>
<tr>
<td></td>
<td>Refurbishment of Valentia ward completed with sufficient personal space now available. Dining room opened. Ligature points minimised in newly refurbished ward.</td>
<td>Premises Audits</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing Audits will be conducted</td>
<td>Through ongoing audits</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>Executive Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000147</th>
<th>Residents did not have access to outside space 22 (3).</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>Corrective Action</td>
<td>Complete refurbishment of Valentia ward. Outside space is expected to be accessible to residents from August 2019</td>
<td>outside space is expected to be accessible from August 2019</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>Executive Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete refurbishment of Valentia ward. Outside space is expected to be accessible to residents from August 2019</td>
<td>outside space is expected to be accessible from August 2019</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>Executive Clinical Director</td>
</tr>
</tbody>
</table>
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

**Reason ID: 10000148**

In two MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident, 23(1). Two MPARs did not record the stop date for each medication, 23(1). One MPAR did not have the Doctors Medical Council Registration Number (MCRN) documented on the MPAR, 23(1).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All staff advised of findings of inspectors via unit staff meeting and the important of accurate and complete recording for same</td>
<td>Staff are aware of non compliance, monthly MPAR audits.</td>
<td>Achievable</td>
<td>31/07/2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Executive Clinical Director and Area Director of Nursing</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Monthly MPAR audit. Requirements stressed at induction for new staff</td>
<td>Monthly Audits and all staff will be advised of requirements during induction</td>
<td>Achievable</td>
<td>31/07/2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Executive Clinical Director and Area Director of Nursing</td>
</tr>
</tbody>
</table>
### Regulation 25: Use of Closed Circuit Television

**Reason ID: 10000151**

There were no clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV was not clearly labelled, 25 (1)(b).

<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>Signage put in place</td>
<td>Signage put in place immediately</td>
<td>Achieved</td>
<td>01/07/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<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>Signage put in place</td>
<td>Signage put in place immediately</td>
<td>Achieved</td>
<td>01/07/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Reason ID: 10000152**

Not all staff had up-to-date mandatory training in Basic Life Support, fire safety or PMAV 26(4). Not all staff had up to date mandatory training in the Mental Health Act 2001, 26(5).

<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>Specific: Schedule of training dates developed</td>
<td>Training dates identified</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Heads of Discipline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each Head of Discipline will review the records in respect of their staff on a quarterly basis and follow up appropriately. All new staff advised to complete at induction if not already done</td>
<td>Each Head of Discipline to review training records in respect of all staff in their remit</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Heads of Discipline</td>
</tr>
</tbody>
</table>
### Regulation 27: Maintenance of Records

#### Reason ID: 10000154

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Preventative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit completed and results fed back at unit staff meeting</td>
<td>Is part of medical staff induction programme. All consultants to monitor at ward rounds. Regular audit to commence using 'safety cross' method</td>
</tr>
<tr>
<td>Achieved</td>
<td>Achievable</td>
</tr>
<tr>
<td>01/07/2019</td>
<td>31/07/2019</td>
</tr>
<tr>
<td>Executive Clinical Director</td>
<td>Executive Clinical Director</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000155

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Preventative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward clerk to secure all loose pages</td>
<td>Weekly worksheet to be completed by ward clerk regarding maintenance of files. Reviewed by the Mental Health Act Administrator. Standing item on agenda of unit meeting</td>
</tr>
<tr>
<td>Records secured</td>
<td>Worksheet reviewed weekly by Mental Health Act administrator. Findings a standing item on agenda of unit meeting</td>
</tr>
<tr>
<td>Achieved</td>
<td>Achievable</td>
</tr>
<tr>
<td>01/07/2019</td>
<td>01/07/2019</td>
</tr>
<tr>
<td>Area Administrator and Ward Clerk</td>
<td>MHA Administrator and Heads of Discipline</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000156

<table>
<thead>
<tr>
<th>Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records were not secure in Valentia Ward</td>
</tr>
<tr>
<td>Achieved</td>
</tr>
<tr>
<td>01/07/2019</td>
</tr>
<tr>
<td>MHA Administrator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Records secured</th>
<th>Records secured</th>
<th>Achieved</th>
<th>01/07/2019</th>
<th>Executive Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Action</td>
<td>Records secured</td>
<td>Records secured</td>
<td>Achieved</td>
<td>01/07/2019</td>
<td>Executive Clinical Director</td>
</tr>
</tbody>
</table>
Regulation 32: Risk Management Procedures

<table>
<thead>
<tr>
<th>Reason ID : 10000157</th>
<th>The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre. 32 (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Specific: Opening of Reask ward to reduce structural risks and address concerns raised regarding privacy on Valentia ward</td>
</tr>
<tr>
<td></td>
<td>Measurable: opening of Reask Ward</td>
</tr>
<tr>
<td></td>
<td>Achievable/Realistic: Achieved</td>
</tr>
<tr>
<td></td>
<td>Time-bound: 31/07/2019</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s): Executive Clinical Director and Risk Manager</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Specific: Opening of Reask Ward to reduce structural risks and address concerns raised regarding privacy on Valentia Ward. Ongoing monitoring of risk register.</td>
</tr>
<tr>
<td></td>
<td>Measurable: Quarterly audits</td>
</tr>
<tr>
<td></td>
<td>Achievable: Achievable</td>
</tr>
<tr>
<td></td>
<td>Time-bound: 31/10/2019</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s): Executive Clinical Director and Risk Manager</td>
</tr>
</tbody>
</table>
### COP Relating to Admission of Children under the Mental Health Act 2001.

**Reason ID : 10000122**  
Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Relevant adult allied health professionals will liaise with CAMHS counterparts at MDT ICP meetings regarding appropriate services, following each admission and within 2 - 3 days of admission.</td>
<td>Quarterly audit of child admissions</td>
<td>Achievable</td>
<td>01/08/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Devise a list of appropriate personnel who may be available at short notice to deliver appropriate activities following an emergency admission of a child. Identify appropriate budget for funding same. Progress the development of a child specific care plan.</td>
<td>Quarterly audit of child admissions</td>
<td>Achievable</td>
<td>02/09/2019</td>
</tr>
</tbody>
</table>

**Reason ID : 10000123**  
Children did not have access to age-appropriate advocacy services, 2.5 (g).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
</table>

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AC0055 Sliabh Mis Mental Health Admission Unit, University Hospital Kerry  
Approved Centre Inspection Report 2019  
Page 90 of 101
<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>CAMHS service to identify appropriate advocacy service</th>
<th>Quarterly audit</th>
<th>Achievable</th>
<th>30/08/2019</th>
<th>CAMHS Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Action</td>
<td>Include in audit of child admissions</td>
<td>Quarterly audit</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>Executive Clinical Director</td>
</tr>
</tbody>
</table>

**Reason ID: 10000124**

One child did not have their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical file did not record this child's understanding of the explanation given because no explanation was given to them. 2.5, (h). In one case, there was no documented form and evidence to indicate whether consent for treatment was obtained from at least one parent, 3.2.

<table>
<thead>
<tr>
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<th>Time-bound</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Develop admission check list specific to child admissions</td>
<td>Admission checklist</td>
<td>Achievable</td>
<td>30/09/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Develop admission check list specific to child admissions</td>
<td>Admission checklist</td>
<td>Achievable</td>
<td>30/09/2019</td>
</tr>
</tbody>
</table>
In two of the episodes of physical restraint reviewed it was not recorded in the clinical file if the consultant psychiatrist had been informed of the physical restraint as soon as was practicable, 5.3. In two of the episodes of physical restraint reviewed the clinical practice form had not been signed by a consultant psychiatrist, 5.7 (c). In two episodes of physical restraint, the clinical practice form was not placed in the clinical file, 8.3.

<table>
<thead>
<tr>
<th>Reason ID: 10000126</th>
<th>Code of Practice on the Use of Physical Restraint in Approved Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Restraint pathway and checklist in place. A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh Mis. 3 monthly audit of episodes of restraint Achievable 30/09/2019 Executive Clinical Director and Area Director of Nursing</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh Mis. 3 monthly audit of episodes of restraint Achievable 31/10/2019 Executive Clinical Director and Area Director of Nursing</td>
</tr>
</tbody>
</table>

In one of the episodes of physical restraint reviewed a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint, 5.4.

<table>
<thead>
<tr>
<th>Reason ID: 10000127</th>
<th>Code of Practice on the Use of Physical Restraint in Approved Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Restraint pathway and checklist in place. A 3 monthly audit of episodes of restraint will be commenced to audit compliance 3 monthly audit of episodes of restraint Achievable 30/09/2019 Executive Clinical Director and Area Director of Nursing</td>
</tr>
</tbody>
</table>
Preventative Action

| Preventative Action | A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh | 3 monthly audit of episodes of restraint | Achievable | 30/09/2019 | Executive Clinical Director and Area Director of Nursing |

Reason ID: 10000129

| Reason ID: 10000129 | In two physical restraint episodes, residents were not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was not documented in either case, 5.8. In one episode of physical restraint the resident’s next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in one case, 5.9 (a). |  |

Corrective Action

| Corrective Action | Restraint pathway and checklist in place. A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh | 3 monthly audit of episodes of restraint | Achievable | 30/09/2019 | Executive Clinical Director and Area Director of Nursing |

Preventative Action

| Preventative Action | A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh | 3 monthly audit of episodes of restraint | Achievable | 30/09/2019 | Executive Clinical Director and Area Director of Nursing |

Reason ID: 10000131

<p>| Reason ID: 10000131 | In one physical restraint episode, there was no documented record to indicate that the episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode, 9.3. |  |</p>
<table>
<thead>
<tr>
<th>Corrective Action</th>
<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></td>
<td>Restraint pathway and checklist in place. A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh Mis.</td>
<td>3 monthly audit of episodes of restraint</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>A 3 monthly audit of episodes of restraint will be commenced to audit compliance with same by CNM2s Sliabh</td>
<td>3 monthly audit of episodes of restraint</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
</tr>
</tbody>
</table>

Reason ID : 10000132

The approved centre did not maintain a written record to indicate that all staff involved in physical restraint had read and understood the policy, 9.2 (b).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<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></td>
<td>All Heads of Discipline reminded to take appropriate steps in writing to ensure their staff read and understand policies and sign written record of same</td>
<td>Staff notification to issue</td>
<td>Achievable</td>
<td>01/08/2019</td>
<td>Heads of Discipline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Area management Team to develop an escalation action re non signing of policies</td>
<td>MHMT meeting Aug 2019</td>
<td>Achievable</td>
<td>31/10/2019</td>
<td>Kerry Mental Health Services Management Team</td>
</tr>
</tbody>
</table>
Code of Practice on Admission, Transfer and Discharge to and from an approved centre

Reason ID : 10000134

The admission policy did not include reference to pre-admission assessments and reference to admission referral letters, 4.3. The discharge policy did not include procedures for managing discharge against medical advice, 4.15 Not all relevant staff had signed the signature log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1. Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies, 4.19.

<table>
<thead>
<tr>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Admission, Transfer and Discharge policy in development will include reference to pre-admission assessment and referral letters and discharge against medical advice All line managers to be advised to ensure staff under their management are aware of need to sign revised policies once approved. Audit of adherence to new policy will be undertaken 1 month after final approval.</td>
<td>First draft policy has been completed and is currently being reviewed</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>

Preventative Action

First draft completed, amendments First draft policy has been completed and is Achievable 31/10/2019 Executive Clinical Director and Area Director of Nursing
ongoing re pre admission assessment and referral letter. Submit for approval to PPPG group when 2nd draft completed. All line managers to be advised to ensure staff under their management are aware of need to sign revised policies once approved. Audit of adherence to new policy will be undertaken 1 month after final approval.
### Rules Governing the Use of Seclusion

**Reason ID: 10000158**

In one episode of seclusion, the seclusion register was not signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours, 3.5.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to seclusion pathway by all staff</td>
<td>Audit results 3 monthly</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of seclusion</td>
<td>Audit Results 3 monthly</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>

**Reason ID: 10000159**

The seclusion policy did not include ways of reducing rates of seclusion use, 10.2 (a)

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All RCPs advised again of their responsibility re same and will be raised again at monthly consultants meetings Audit of seclusion pathway adherence</td>
<td>Audit results 3 monthly</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of Seclusion</td>
<td>Audit Results 3 monthly</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>Executive Clinical Director and Area Director of Nursing</td>
<td></td>
</tr>
</tbody>
</table>
### Part 4 of the Mental Health Act 2001: Consent to Treatment

**Reason ID: 10000138**

There was no documented evidence to indicate that the consultant psychiatrist had undertaken a capacity assessment.

<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>Memo to be issued to all Consultant staff</td>
<td>Audit</td>
<td>Achieved</td>
<td>01/07/2019</td>
<td>Executive Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Specific</th>
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<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular audit of consent to medication process to begin</td>
<td>Audit</td>
<td>Achievable</td>
<td>31/07/2019</td>
<td>Executive Clinical Director</td>
<td></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.