Admission Unit & St. Edna's Unit, St Loman's Hospital

ID Number: AC0006

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Admission Unit & St. Edna's Unit, St Loman's Hospital
Delvin Road
Mullingar
Co Westmeath

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Other

Conditions Attached:
Yes

Registered Proprietor:
HSE

Most Recent Registration Date:
1 March 2017

Registered Proprietor Nominee:
Ms Ger McCormack, General Manager Mental Health Services, MLM CHO

Inspection Date:
28 – 31 May 2019

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
23 – 26 October 2018

Date of Publication:
Friday 28 February 2020

2019 COMPLIANCE RATINGS

REGULATIONS
26
4
1
Non-compliant
Compliant
Codes of Practice
3
Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH
3
1

COMPLIANCE RATINGS
1
1

RULES AND PART 4 OF THE MENTAL HEALTH
Compliant
Non-compliant
Not applicable

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3
Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH
3
1

COMPLIANCE RATINGS
1
1

RULES AND PART 4 OF THE MENTAL HEALTH
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

St. Loman’s approved centre in Mullingar comprised two units, the Admission Unit and St. Edna’s Unit, providing accommodation for up to 44 residents. St. Edna’s Unit provided continuing care for male residents only, most of whom had been in the approved centre for a number of years. A number of the residents in St. Edna’s Unit had psychogenic polydipsia and required a specific management plan and observation. Four community mental health teams, a psychiatry of later

The average bed occupancy levels over the previous three month period, which ranged from 60% in St. Edna’s Unit and 38-60% in the Admission Unit.

There has been ongoing improvement in compliance with regulations, rules, and codes of practice, from 66% compliance in 2017; 72% in 2018 to 89% in 2019. Four compliances with regulations were rated as excellent.

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

**Condition 1:** To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in the form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of the condition. The approved centre was non-compliant with Regulation 26: Staffing, with a risk rating of high at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food and the kitchens were clean.
- The ordering, prescribing, storage and administration of medication process were excellent and reflected safe practice.
- There was a significant increase in mandatory training of nursing staff in fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act 2001.
However:

- Consultant psychiatrists, health and social care professionals and non-consultant hospital doctors (NCHD) had significantly low levels of mandatory training in fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act 2001.
- Ligature anchor points had not been minimised to the lowest practicable level. At the time of the inspection, a number of ligature points were present inside of the approved centre, including taps, shower fittings, and window handles.

Appropriate care and treatment of residents

- Each resident had an individual care plan (ICP) which reflected resident’s needs, goals, required interventions and who was responsible for providing the interventions. Both residents and the multidisciplinary team were involved in the development and review of the care plans.
- There were evidenced based therapeutic services and programmes available. A number of nurse led groups ran in both the assessment Ward and St. Edna’s Ward. These included Decider Skills and a Recovery Group, which were facilitated by nursing staff with specific training. Occupational therapists ran a daily exercise group and a baking and gardening group twice a week. A Crafts and Creation Group and a Relaxation Group took place each week. Twice yearly, a 12 week psychology group was facilitated in St. Edna’s Ward. A social work group that focused on socialisation and had established links with a local transformation college was facilitated on a weekly basis, when the psychology group was not running.
- All residents had received a physical examination at least every six months. Residents on antipsychotic medication received an annual assessment of their glucose regulation, prolactin levels, and blood lipids.

However:

- While residents had received a six-monthly general health assessment, this had not been adequately completed. Residents’ Body Mass Index (BMI) were not checked and recorded in four cases. Two of the five residents did not receive an assessment of their waist circumference. Residents’ nutritional status was not documented in two cases. Two residents on antipsychotic medication did not receive an annual assessment of their heart health through an electrocardiogram (ECG).

Respect for residents’ privacy, dignity and autonomy

- Residents had access to personal space, including outdoor space. In St. Edna’s Ward, all sleeping accommodation consisted of single, en suite bedrooms. In the Admission Unit, accommodation consisted of single and two-bed en suite rooms.
- A cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours.
• Internal Courtyards on both units had been redeveloped and refurbished with new planting and surface dressings.
• The searches of residents and their property were implemented with due regard to the resident’s dignity, privacy and gender, and at least one of the staff members who conducted the search was the same gender as the resident being searched. All searches were documented in the resident’s clinical file.
• Visiting times were publicly displayed at the hospital entrance and in each ward of the approved centre. A separate visiting area was provided where residents could meet visitors in private.
• CCTV was used in the High Dependency Unit only. There were clear signs in prominent positions to indicate where CCTV cameras were located. CCTV cameras used to observe residents were incapable of recording or storing a resident’s image and was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident.
• Seclusion was used in accordance with the Rules Governing the Use of Seclusion, while the use of physical restraint was in accordance with the Code of Practice on Physical Restraint.

However:

• Maintenance was reactive to demand; there was no documented programme of proactive maintenance, including general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was evidence of exposed unshielded wiring, a number of broken doors and cracked ceiling glass.
• The corridors in St. Edna’s ward were noticeably cold. No radiators were operating in the corridors of the approved centre. Bedroom areas were adequately heated.
• Some furnishings were worn and in a poor state of repair.
• All residents in the Acute Unit had restricted access to their own phones rather than on an assessed individual risk basis. Residents handed their phones in upon admission to the approved centre, but could use their mobiles on a ‘by request’ basis. This impacted on their autonomy and dignity.

Responsiveness to residents’ needs

• The approved centre’s menus were approved by a dietitian employed by Mullingar Hospital to ensure nutritional adequacy in accordance with the residents’ needs. Meals were nutritious and there were at least two choices for meals.
• Residents’ nutritional and dietary needs were assessed and their special nutritional requirements were regularly reviewed by a dietitian.
• Information about the approved centre, medications and diagnosis was provided. An information leaflet on polydipsia had been developed for both service users and family members.

However:

• The approved centre provided very limited access to recreational activities such as TV, DVDs, games, books, a daily newspaper, crossword, and word wheel sessions. Weekly outings and walks were organised but this was dependant on staff availability and having sufficient financial resources. An
enhanced recreational programme was planned and an occupational therapy assessment was ongoing. A greater range of further recreational activities could be provided if additional funds, in excess of the current amount of €50 per month for the entire resident group, were provided.

**Governance of the approved centre**

- The approved centre was part of the Midland Louth Meath Community Healthcare Organisation. The area management team meetings occurred monthly and there was clear evidence of well-structured governance arrangements and processes in place reflecting the Longford/Westmeath Mental Health Services.
- The management team actively and comprehensively addressed issues such as Mental Health Commission (MHC) reports and action plans, the risk register, serious incidents, complaints, with items such as service development, and staff training and development being regularly discussed.
- Strategic goals were aimed at achieving stable staffing for the service to develop sub-specialties which the service identified as being poorly resourced, and to improve and deliver on the principles of the Recovery Framework through allied health professionals (AHPs) interventions such as in individual practice and through group work.
- A Quality and Safety team was in place within the approved centre and it met with the Senior Management Team once a month.
- The approved centre held local clinical governance meetings monthly, rotating bi-monthly for each ward. The agenda items included individual care planning, therapeutic activities, compliments and complaints, and staffing.
- The management team had received training on clinical risk management, the National Incident Management System, and Health and Safety. Operational risks identified across the departments focused mainly on ligature risks, staff shortages and recruitment difficulties. Clinical risks centred on the needs of residents with psychogenic polydipsia and the necessary restrictions impacting on the care arrangements of other residents. Where applicable, these issues had been escalated to the risk register.
- It was evident that there were systems in place to support quality improvement that included the HSE Best Practice Guidance for Mental Health Service, QSUS and the monthly Quality and Patient Safety meetings.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A resident transfer book was developed and implemented by hospital administration staff.

2. A checklist for each of the following resident processes; transfer, resident admission and resident discharge, had been implemented as an aid to promote compliance with the relevant Codes of Practice.

3. Internal Courtyards on both units had been redeveloped and refurbished with new planting and surface dressings.

4. A successful application was made to Tobacco Free Ireland for a bursary to implement the Tobacco Free Campus (TFC) policy. This was supported by a dedicated Quality Improvement Plan (QIP) and the re-establishment of the TFC multi-disciplinary team (MDT) working group.

5. The seclusion care plan had been reviewed and redeveloped. The reviewed seclusion pack contained a compliance checklist, a debriefing tool, and a service user information leaflet.

6. An information leaflet on polydipsia had been developed for both service users and family members.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Loman’s approved centre in Mullingar comprised two units, the Admission Unit and St. Edna’s Unit, providing accommodation for up to 44 residents. The Admission Unit catered for male and female residents. St. Edna’s Unit provided continuing care for male residents only, most of whom had been in the approved centre for a number of years (eleven residents in St. Edna’s Ward and one resident in the Admission Ward were resident for more than six months). Significantly, a number of the residents in St. Edna’s Unit had psychogenic polydipsia and required a specific management plan. In St. Edna’s, all sleeping accommodation consisted of single, en suite bedrooms. In the Admission Unit, accommodation consisted of single and two-bed en suite rooms.

During the inspection, there were 20 residents in total in the approved centre. There were 12 residents in St. Edna’s and a further 8 residents (two were on leave) in the Admission Unit, reflecting 8 vacancies in St. Edna’s and 16 vacancies in the Admission Unit on the first day of the inspection. This was also reflected in average bed occupancy levels over the previous three month period, which ranged from circa 60% in St. Edna’s Unit and 38-60% in the Admission Unit.

Four community mental health teams, a psychiatry of later life team, a rehabilitation and recovery team, and the Community Alcohol and Drugs Service admitted residents to the approved centre.

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>44</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>20</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>4</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>12</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was part of the Midland Louth Meath Community Healthcare Organisation and encompassed the governance of both Longford/Westmeath Mental Health Services, and the Laois Offaly Mental Health Services. The area management team meetings occurred monthly and there was clear evidence of well-structured governance arrangements and processes in place reflecting the Longford/Westmeath Mental Health Services. Management meetings were attended by heads of discipline, the general manager, the risk and patient safety advisor and the area lead for mental health engagement.
Copies of the monthly minutes of the Longford/Westmeath Mental Health Services management team meetings, Quality and Patient Safety and supporting committees such as the audit committee were provided to the inspection team. They indicated that the management team actively and comprehensively addressed issues such as Mental Health Commission (MHC) reports and action plans, the risk register, serious incidents, complaints, with items such as service development, and staff training and development being regularly discussed. Strategic goals were aimed at achieving stable staffing for the service to develop sub-specialties which the service identified as being poorly resourced, and to improve and deliver on the principles of the Recovery Framework through allied health professionals (AHPs) interventions such as in individual practice and through group work.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place. A Quality and Safety team was in place within the approved centre and it met with the Senior Management Team once monthly to report on initiatives in place and those planned. The monthly Quality and Safety meetings dealt with specific items pertaining to the approved centre and included a progress report, complaints, incidents and any serious reportable event. The approved centre held local clinical governance meetings monthly, rotating bi-monthly for each ward; therefore, each ward had a separate clinical governance meeting every second month. Agenda items included individual care planning, therapeutic activities compliments and complaints, and staffing.

The MHC’s governance questionnaire was completed by the approved centre’s Clinical Director, Principal Psychology Manager, Occupational Therapy Manager, Principal Social Worker, and the Area Director of Nursing. These indicated that there were clear reporting systems for all disciplines and the management had received training on clinical risk management, the National Incident Management System, and Health and Safety. Operational risks identified across the departments focused mainly on ligature risks, staff shortages and recruitment difficulties within medical, nursing and also AHP staff, which resulted in over-reliance on agency staff and overtime. The service identified a need for a number of posts (one pharmacist, one consultant led team, as well as, psychology and nursing staff) as shortages in the community mental health teams (CMHTs) also impacted on service delivery to the approved centres. Clinical risks centred on the needs of residents with psychogenic polydipsia and the necessary restrictions impacting on the care arrangements of other residents. Where applicable, these issues had been escalated to the risk register.

For those departments with no staff performance appraisal system clinical supervision was provided. It was evident that there were systems in place to support quality improvement that included the HSE Best Practice Guidance for Mental Health Service, QSUS and the monthly Quality and Patient Safety meetings.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X High</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>X High</td>
<td>X High</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines</td>
</tr>
</tbody>
</table>

4.3 Areas that were not applicable on this inspection
<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint.</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

The inspection team spoke individually with seven residents to gain feedback on their experience within the approved centre and also received two completed questionnaires. Generally, residents were complimentary of food, the range of activities, as well as staff, in terms of their care and engagement with multi-disciplinary (MDT) staff. Some of the residents were well informed of the Inspector’s role and were keen to engage. They were also aware of their care plan and had a key nurse but stated that this changed every day.

A universal theme was the significant difference that the occupational therapy programme, with a dedicated occupational therapist for each unit, had brought to the range of therapeutic programmes available to both units. One resident stated that on a previous admission there had been nothing to stimulate them ‘physically or mentally’; however, on this admission they felt active, and purposely engaged. Those that had their own phone were happy with the current arrangements regarding access and safekeeping.

Any concerns or queries raised by the residents were referred with their permission, to their key worker for follow-up.
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:

- Clinical Director
- Social Worker Team Leader
- Quality and Risk Advisor
- Principal Psychology Manager Longford Westmeath Mental Health Service
- Occupational Therapy Manager
- Senior Occupational Therapist
- Acting Clinical Nurse Manager 2
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 X 2
- Registered Psychiatric Nurse
- Area Director of Nursing
- Maintenance Manager
- Mental Health Act Administrator
- Consultant Psychiatrist, Rehabilitation and Recovery
- Acting Assistant Director of Nursing
- Business Manager
- Administrator, Longford Westmeath MHS

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 services reported that a working group had been formed to address both the needs of those with polydipsia and to further assist those residents impacted indirectly by polydipsia.
- All of the policies identified as having missing elements of the Judgement Support Framework had been reviewed and were awaiting sign-off.
- A named consultant psychiatrist and a consultant anaesthetist had been identified specifically for the Electro-Convulsive Therapy (ECT) programme.
- An audit of six-monthly physicals has been scheduled for September 2019.
- Clarity was provided that the feedback meeting did not confirm whether compliance or non-compliance had been achieved, and that reviews or revisions to corrective and preventative action plans (CAPAs) will be subject to the findings of this inspection by the MHC Standards and Quality Assurance Division.

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 October 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The approved centre used the name, medical record number, and date of birth of each resident as identifiers. The identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate sticker alerts were used to inform staff of the presence of residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: The approved centre’s menus were approved by a dietitian employed by Mullingar Hospital to ensure nutritional adequacy in accordance with the residents’ needs. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Residents had at least two choices for meals. Hot meals were served daily. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly and fresh water was available from dispensers on each ward.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Their special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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

COMPLIANT
Quality Rating Excellent
Regulation 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 September 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. Staff 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, and a temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

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

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the 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 May 2017. The policy included the requirements of the Judgement Support Framework, with the exception of the recording the wearing of nightclothes during the day in residents’ individual care plans (ICPs).

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 not monitored on an ongoing basis. A record of residents wearing night clothes during the day, as indicated by their ICP, was maintained and monitored.

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in May 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 residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were not monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis, in accordance with the approved centre’s policy.

Secure facilities, including two safes, were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident, or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

The approved centre was 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 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in December 2017. The policy included the requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities relating to the provision of recreational activities within the approved centre.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission. The weekly activity timetable was displayed on noticeboards.

Activities included TV, DVDs, games, books, a daily newspaper, crossword, and word wheel sessions. Weekly outings and walks were organised but this was dependent on staff availability and having sufficient financial resources. An assessment of recreational activities was taking place by the occupational therapist with a view to providing an enhanced recreational programme.

The recreational activities provided by the approved centre were not appropriately resourced. A greater range of further recreational activities could be provided if additional funds, in excess of the current amount of 50 euro per month for the entire resident group, were provided.

Opportunities were available for indoor and outdoor exercise and physical activity. Communal rooms were large enough to suitably support recreation activities. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in a recreation log.

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, monitoring and evidence of implementation pillars.
Regulation 10: Religion

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre. Residents had access to multi-faith chaplains and had access to local religious services, including a local Mass service, and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice, in line with their wishes.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: No resident had visitor restrictions applied at the time of the inspection. Analysis had not been completed to identify improvement.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed at the hospital entrance and in each ward of the approved centre. A separate visiting area was 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. It was possible for visits to take place in the sitting room of one Ward.

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 sitting room available was suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the 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 and procedures in relation to resident communication, which was last reviewed in May 2017. The policy included the requirements of the Judgement Support Framework, with the exception of the individual risk assessment requirements in relation to limiting resident communication activities.

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, email, internet, and telephone as desired. Wi-Fi was not available in the approved centre. Residents in the Acute Unit had restricted access to their own phones; residents handed their phones in upon admission to the approved centre, but could use their mobiles on a ‘by request’ basis. This practice was in the interest of resident safety and privacy.

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 a 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 processes and monitoring pillars.
Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had not 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. General written consent was sought for routine environmental searches. The clinical file for one resident who was searched was inspected. Risk had been assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. The resident’s consent was sought and documented, prior to the search taking place.
The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

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

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
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 four written operational policies and protocols in relation to care of the dying: the care of the dying policy was last reviewed in December 2017; the policy relating to the unexpected death of a patient was last reviewed in May 2017; the DNAR Directives were last reviewed in September 2018; and the last office procedure was last reviewed in May 2017. The care of the dying 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.

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Residents had been assessed at admission by the admitting clinician, and an initial ICP was completed by the admitting clinician to address the immediate needs of the resident. All residents received an evidenced-based comprehensive assessment within seven days of admission. Each ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, and next of kin, as appropriate. Residents’ families were involved in residents’ ICPs, with the residents’ consent.

The ICPs identified residents’ assessed needs, appropriate goals, and the care and treatment required to meet the identified goals, including the frequency and staff responsibilities for implementing the care and treatment. The ICPs identified the resources required to provide the care and treatment identified and also included a risk management plan.

The ICPs were reviewed regularly by the MDT, in consultation with the resident. Residents had access to their ICPs and were kept informed of any changes. Not all residents were offered a copy of their ICP, including any reviews. In one of the ten cases, when a resident declined or refused a copy of their ICP, the reason for this was not documented.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

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

- The planning and provision of therapeutic services and programmes within the approved centre.
- Assessing residents as to the appropriateness of services and programmes (including risk).
- The resource requirements of the therapeutic services and programmes.
- The review and evaluation of therapeutic services and programmes.

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

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

Evidence of Implementation: All therapeutic services and programmes provided by the approved centre were extensive, evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans. All therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of therapeutic services and programmes provided within the approved centre was available to residents, but the list did not accurately reflect the range of therapeutic services and programmes provided in the approved centre. There was much more therapeutic services and programmes provided in the approved centre, than what was included on the list.

A number of nurse led groups ran in both the Assessment Ward and St. Edna’s Ward. These included Decider Skills and a Recovery Group, which were facilitated by nursing staff with specific training. Occupational therapists ran a daily exercise group and a baking and gardening group twice a week. A crafts and Creation Group and a Relaxation Group took place each week. The occupational therapists worked on a one to one basis with a number of the residents on an assessed needs basis.

Twice yearly, a 12 week psychology group was facilitated in St. Edna's Ward. A social work group that focused on socialisation and had established links with a local transformation college was facilitated on a weekly basis, when the psychology group was not running.
Adequate resources and facilities were available. Therapeutic services and programmes were provided in separate dedicated rooms, and each ward had facilities to carry out group programmes or one-to-one sessions. 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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The transfer policy was last reviewed in May 2017. The policy included the requirements of the Judgement Support Framework, with the exception of the process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.

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

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

Evidence of Implementation: The clinical file of one resident, who had been transferred from the approved centre in a non-emergency situation, was examined. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This communication included the reasons for transfer, the resident’s care and treatment plan, including needs and risks, and the resident’s accompaniment requirements on transfer.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies and procedures in relation to the provision of general health services and the response to medical emergencies, which were last reviewed in May 2017. The policies combined included the requirements of the Judgement Support Framework, with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- The staff training requirements in relation to basic life support.

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

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

Evidence of Implementation: Staff in the approved centre had an emergency resuscitation trolley, and they had access to an Automated External Defibrillator. The emergency equipment was checked weekly. The five clinical files inspected showed that residents received appropriate general health care interventions in accordance with identified needs documented in their ICPs. Registered medical practitioners assessed residents’ general health needs at admission, and when indicated by the residents’ specific needs.

Resident’s general health needs were monitored and assessed at least every six months. While the five residents had received a six-monthly general health assessment including a physical examination, the assessments had not been adequately completed. Residents’ Body Mass Index were not checked and recorded in four cases. Two of the five residents did not receive an assessment of their waist circumference. Residents’ nutritional status was not documented in two cases.

Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Residents on antipsychotic medication received an annual assessment of their glucose regulation, prolactin levels, and blood lipids. Two residents on antipsychotic medication did not receive an annual assessment of their heart health through an electrocardiogram.
Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.

The approved centre was non-compliant with this regulation because the six-monthly general health assessment records and associated tests were not fully complete due to the following:

a) Residents’ Body Mass Index was not checked and recorded in four out of five cases, 19(1)(b).
b) Two of the five residents did not receive an assessment of their waist circumference, 19(1)(b).
c) Nutritional status was not documented in two out of five cases, 19(1)(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents, which was last reviewed in May 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

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

Information was not provided to residents on diagnosis or the likely adverse effects of treatments, including the risks and other potential side-effects of medication. Medication information sheets, indications for the use of all medications to be administered to the resident, and verbal information were not provided to residents.

Information was available electronically via staff but residents were not informed of this availability (through notices or other means) and were therefore not aware of this access. Staff were not familiar with access processes.
The electronic information documents provided within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services 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 training, monitoring, and evidence of implementation 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 May 2017. The policy addressed all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents were accommodated in single bedrooms. Staff were discreet when discussing residents’ conditions or treatment needs. Residents wore clothing that respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors, unless there was an identified risk to residents.

Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls; a cordless phone was available.

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 pillar.
Regulation 22: Premises

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

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

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

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as 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 the premises, which was last reviewed in May 2017. The policy included requirements of the Judgement Support Framework, with the following exceptions:

- The approved centre’s utility controls and requirements.
- The identification of hazards and ligature points in the premises.

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

Monitoring: The approved centre had completed separate ligature audits and hygiene audits. A documented analysis was completed to identify opportunities to improve the premises.

Evidence of Implementation: Residents had access to personal space, including suitable single bedrooomed accommodation and outdoor space. Communal rooms were appropriately sized. Communal areas were adequately lit to facilitate reading and other activities. Appropriate signage was in place to support resident orientation needs. Hazards were minimised, but ligature anchor points had not been minimised to the lowest practicable level. At the time of the inspection, a number of ligature points were present inside of the approved centre, including taps, shower fittings, and window handles.

The corridors in St. Edna’s ward were noticeably cold. One resident wanted the windows to remain open for ventilation. No radiators were operating in the corridors of the approved centre. Bedroom areas were adequately heated. It was outlined that two separate heating systems were in operation within the approved centre.
A cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours.

Maintenance was reactive to demand; there was no documented programme of proactive maintenance, including general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was evidence of exposed unshielded wiring, a number of broken doors and cracked ceiling glass. The approved centre did not provide suitable furnishings to support resident independence and comfort. Furnishings were worn and in a poor state of repair.

Remote or isolated areas of the approved centre were monitored.

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

a) The premises were not maintained in good structural order due to unshielded wiring, broken doors and ceiling glass, 22(1)(a).

b) A programme of renewal of fabric and, in particular, furnishings was not in place, 22(1)(c).

c) The corridors of the premises were not adequately heated, 22(1)(b).

d) The minimisation of ligature points to the lowest practicable level, based on risk assessment, was not undertaken, 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 written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in May 2017. The policies combined included all the requirements of the Judgement Support Framework.

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

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

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

Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident’s care or condition. 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.

Schedule 2 controlled drugs were checked by two staff members, one of which was a registered nurse against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Medication refrigerators were kept locked. 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 by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in May 2017. The policy addressed the requirements of the Judgement Support Framework, with the following exceptions:

- The specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- 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.
  - Support provided to staff following exposure to infectious diseases.
  - Covering of cuts and abrasions
  - The management and reporting of an infection outbreak.
  - Specific infection control measures in relation to C. difficile, MRSA, and Norovirus.
  - Availability of staff vaccinations and immunisations.
  - Management and reporting of an infection outbreak.
- First aid response requirements.
- Falls prevention initiatives.
- Vehicle controls.
- The staff training requirements in relation to health and safety.
- The monitoring and continuous improvement requirements implemented for the health and safety processes.

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

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

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

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

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in March 2017. The policy included the requirements of the Judgement Support Framework with the exception of the maintenance of CCTV cameras by the approved centre.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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 checked regularly to ensure that the equipment was operating appropriately. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions to indicate where CCTV cameras were located in the approved centre. CCTV was used in the High Dependency Unit only. 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 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 26: Staffing

1. The registered proprietor shall ensure that the approved centre has written policies and procedures relating to 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 use the HSE’s National Recruitment Service Policy in relation to its staffing requirements. The staffing policy was last reviewed in 2017. The policy included the requirements of the Judgement Support Framework, with the following exceptions:

- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The process for transferring responsibility from one staff member to another.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan 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. Annual staff training plans were not completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile.

A written staffing plan was available within the approved centre. Staff were trained in manual handling, infection control and prevention, risk management and treatment, and incident reporting. Staff were not
trained in recovery-centred approaches to mental health care and treatment, dementia care, end of life care or resident rights. Staff were trained in the protection of children and vulnerable adults, and in Children First.

There was 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. Staff training was documented and staff training logs were maintained. Not all health care staff were trained in fire safety, Basic Life Support, the management of violence and aggression, and 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 (43)</td>
<td>42</td>
<td>98%</td>
<td>36</td>
<td>84%</td>
<td>42</td>
</tr>
<tr>
<td>Consultant Psychiatrist (11)</td>
<td>6</td>
<td>55%</td>
<td>7</td>
<td>64%</td>
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<tr>
<td>Medical (16)</td>
<td>8</td>
<td>50%</td>
<td>10</td>
<td>63%</td>
<td>7</td>
</tr>
<tr>
<td>Occupational Therapist (7)</td>
<td>7</td>
<td>100%</td>
<td>3</td>
<td>48%</td>
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<tr>
<td>Social Worker (4)</td>
<td>3</td>
<td>75%</td>
<td>3</td>
<td>75%</td>
<td>3</td>
</tr>
<tr>
<td>Psychologist (4)</td>
<td>1</td>
<td>25%</td>
<td>0</td>
<td>0%</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Unit</td>
<td>CNM3</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>St. Edna’s Unit</td>
<td>CNM3</td>
<td>1*</td>
<td>1*</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*Clinical Nurse Manager (CNM), Registered Psychiatrist (RPN), CNM 3 – One W.T.E. for the Approved Centre

*Shared between both Admission Unit and St. Edna’s Unit
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 Professional Management of Violence and Aggression, 26(4).

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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in March 2018. The policy included the requirements of the Judgement Support Framework, with the exception of the retention of inspection reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. 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: All residents’ records inspected were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents’ status at the time of inspection and the care and treatment being provided. Residents’ access to their records was managed in accordance to the Data Protection Acts.

Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation. Not all entries recorded the time using the 24-hour clock. The approved centre did not maintain a record of all signatures used in the resident record.

Only authorised staff made entries in residents’ records. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.
The approved centre was 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, training and education, and evidence of implementation pillars.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

- The process for reviewing and updating operating policies and procedures, at least every three years.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The process for making obsolete and retaining previous versions of operating policies and procedures.
- The standardised operating policy and procedure layout used by the approved centre.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in May 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was analysed, and the details of the analysis were considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person, was publicly displayed on the noticeboard, and it was detailed within the service-users’ information booklets. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made through noticeboards and information booklets. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.
All complaints were handled promptly, appropriately and sensitively. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy. This was documented in the complaints log.

The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints, apart from minor complaints, were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation, and details of the appeals process made available to them.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan. The complainant’s satisfaction, or dissatisfaction, with the investigation findings was documented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
Regulation 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 series of written policies in relation to risk management and incident management procedures. The risk management policy was last reviewed in March 2019. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit measured actions taken to address risks identified against the timeframes identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure
their effective implementation. Clinical nurse managers on each unit had responsibility for the management of individual risk registers. Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes.

Clinical and corporate risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of electroconvulsive therapy, physical restraint and seclusion, and at resident admission and transfer. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

Health and safety risks, including fire risks, were not identified, assessed, reported, treated, monitored, and recorded in the risk register. Two reported fire incidents by residents were rated by the National Incident Management System (NIMS) as negligible; however, this risk needed to be incorporated into each resident’s clinical risk profile. The risk management procedures did not actively reduce the identified risks to the lowest level of risk. Structural risks, including ligature points, remained and were identified, but there was no documented action plan to reduce, remove, or effectively mitigate these risks. Ligature point risks were not documented in the risk register.

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

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. The 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 section 1 of this regulation because the risk management policy was not implemented throughout the approved centre, due to the following:

a) Health and safety risks including fire risks were not identified, assessed, reported, treated, monitored, and recorded in the risk register.

b) The risk management procedures did not actively reduce the identified risks to the lowest level of risk. Structural risks, including ligature points, remained and were identified but there was no documented action plan to reduce, remove, or effectively mitigate these risks. Ligature point risks were not documented in the risk register.
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 on in the foyer of the approved centre.

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

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

Section 59

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

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

INSPECTION FINDINGS

Processes: An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for patients. All elements of the policy complied with the ECT rules. The policies were reviewed annually, and it was last reviewed in May 2019. The protocols in place were developed in line with international best practice and included the following:

- How and where the initial and subsequent doses of Dantrolene were stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hypothermia.

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

Evidence of Implementation: The clinical file of one patient who had received ECT since the last inspection was inspected. ECT was administered in a specified location in a critical care area in Theatre 2 of Mullingar General Hospital. Mullingar General Hospital had an assigned recovery room and treatment room, both of which were adequately equipped. There was a facility to monitor EEG on two channels, and the machines were regularly maintained. The ECT material and equipment were in line with best international practice.

There were up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia, which were not prominently displayed; instead, these details were kept in a folder due to infection control protocols in the assigned ECT theatre. There was a named consultant psychiatrist responsible for ECT management, a named consultant anaesthetist who had overall responsibility for ECT, and an ECT nurse.

The clinical file of one patient who was receiving ECT was examined. Appropriate information on ECT was given by the consultant psychiatrist to enable the patient to make a decision on whether or not to agree to receiving ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that the patient could understand. The patient was informed of their rights to an advocate and had the opportunity to raise questions at any time.
The consultant psychiatrist assessed the patient’s capacity to consent to receiving treatment, and this was documented in the patient’s clinical file. The patient was not deemed capable of consenting to receiving ECT.

ECT was administered according to section 59(1)(b) of the MHA 2001, as amended. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) - Unable to Consent was completed by both consultant psychiatrists for each ECT programme. The Form 16 was sent to the MHC within five days.

Both consultant psychiatrists assessed and recorded the following:

- How ECT will benefit the patient.
- Any discussion with and views expressed by the patient.
- Any assistance provided in relation to the discussion with the patient.
- The patient’s ability to consent to ECT.

A programme of ECT was prescribed by the responsible consultant psychiatrist, and was recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and/or the patient’s next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine.

The ECT record, which was completed after each treatment, was placed in the clinical file and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre and post ECT assessments were detailed and recorded in the clinical file. Adverse events during or following ECT were addressed in full and were recorded. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was compliant with this rule.
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 seclusion policy was last reviewed in March 2019. The policy included all of the relevant guidance criteria of this rule, pursuant to Section 69 of the Mental Health Act 2001, including who may implement seclusion, the provision of information to the resident, and methods for reducing 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 files. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

Clinical files of three residents who had been in seclusion on one occasion each since the last were inspected. The approved centre complied with the code of practice on the use of seclusion across the three episodes.

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.

Each resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. Each resident was informed of the ending of seclusion on all occasions.
All episodes of seclusion were recorded in each resident’s clinical file and all uses of seclusion were recorded in the seclusion register. A copy of the seclusion register was in place within the resident’s clinical file and available to inspectors.

The approved centre was compliant with this rule.
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 file of one patient who had been in the approved centre for more than three months, and who had been in continuous receipt of medication, was examined during the inspection. The patient consented to receiving treatment, of which 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 medications.
  - The effects of the medications, including any risks and benefits.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
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.
### INSPECTION FINDINGS

**Processes:** There was a written policy in place dated December 2018 in relation to the use of physical restraint. The policy was reviewed annually. The policy included all of the guidance criteria of this code of practice.

**Training and Education:** The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy.

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

**Evidence of Implementation:** The clinical files of two residents, which included a total of three episodes of physical restraint, 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 thirty minutes.

Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint. In each case examined, residents’ next of kin were informed about the physical restraint with associated reasons documented. Each of the two residents was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

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

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

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

INSPECTION FINDINGS

Processes: An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. All elements of the policy complied with the code of practice. The policy was reviewed annually, and it was last reviewed in May 2019.

The protocols were developed in line with international best practice and addressed:

- How and where the initial and subsequent doses of Dantrolene were stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hypothermia.

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

Evidence of Implementation: One voluntary resident had received ECT since the last inspection, whose clinical file was inspected. The resident’s capacity to consent was assessed and documented prior to obtaining their consent on receiving ECT treatment. The consultant psychiatrist gave the resident appropriate information on ECT, to enable the resident to make a decision on consent. The resident was provided with all the required information, specified in section 4.1 of this code of practice. An interpreter was available if necessary to explain ECT. Information was provided on the likely adverse effects of ECT, including risk of cognitive impairment and amnesia. The resident’s consent was documented in relation to each episode of ECT treatment.

The approved centre had a dedicated ECT suite, a private waiting room, an adequately equipped treatment room, and a recovery room. There was a facility to monitor EEG on two channels, and the machines were regularly maintained. The material and equipment, including emergency drugs, were in line with best international practice.

There were up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia, which were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT, and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The resident’s clinical status, and cognitive status was assessed before and after each ECT programme and were detailed in the resident’s clinical file after each treatment. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was compliant with this code of practice.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident’s family member was involved in the admission process, with the resident’s consent. The resident received an admission assessment, which included the resident’s presenting problem, family and medical history, past psychiatric history, current and historic medication, current mental state, a risk assessment, and assessment of social and housing circumstances. The resident received a full physical examination.

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 addressed early warning signs of relapse and risk. 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 sent to the general practitioner/primary care/community mental health team. A discharge summary was issued to relevant personnel. The discharge summary 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. Risk issues such as signs of relapse were addressed in the discharge summary issued.

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

### Regulation 19: General Health

**Reason ID:** 10000623  
**The six-monthly general health assessment records and associated tests were not fully complete for the following reasons:**  
- Residents’ Body Mass Index was not checked and recorded in four out of five cases, 19(1)(b).  
- Two of the five residents did not receive an assessment of their waist circumference, 19(1)(b).  
- Nutritional status was not documented in two out of five cases, 19(1)(b).  

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
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</tr>
<tr>
<td>Six monthly physical examination form to be amended. Clinical Director to send a memo to Nursing Staff regarding BMI(Waist Circumference and Weight)</td>
<td>Further Training will take place in January 2020</td>
<td>Achievable and Realistic</td>
<td>30/04/2020</td>
<td>Clinical Director</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
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</tr>
<tr>
<td>Audit</td>
<td>Six monthly physicals will be reaudited and will be audited every 6 months thereafter</td>
<td>Achievable and Realistic</td>
<td>30/04/2020</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

#### Reason ID: 10000628

The premises were not maintained in good structural order due to unshielded wiring, broken doors and ceiling glass, 22(1)(a).

<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>Unshielded wiring has been dealt with. The broken doors/handles have been repaired. A submission for funding has been made to repair the Ceiling Glass.</td>
<td>Maintenance Plan in place - see attached document</td>
<td>Achievable and realistic unless the submission for funding is refused</td>
<td>30/06/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Maintenance advised to complete all jobs before leaving the area. Follow up of any outstanding issues to be forwarded to the Hospital Administrator for follow up with Maintenance. Maintenance Manager to attend CAPA meetings.</td>
<td>Maintenance Plan in place</td>
<td>Achievable and realistic</td>
<td>30/06/2020</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000629

A programme of renewal of fabric and, in particular, furnishings was not in place, 22(1)(c).

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Painting of units and new couches complete and new anti-ligature blinds are installed. The upgrade of the toilet in St. Edna's Ward commenced on 2/1/2020 and will be complete by 10/01/2020.</td>
<td>Clinical Nurse Manager II to inspect wards on a monthly basis</td>
<td>Achievable and realistic</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Nursing staff to submit requests to Hospital Administrator on a quarterly basis</td>
<td>Clinical Nurse Manager II to inspect wards on a monthly basis</td>
<td>Achievable and Realistic</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Reason ID: 10000630</td>
<td>The corridors of the premises were not adequately heated, 22(1)(b).</td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>Staff to ensure windows are kept closed based on temperature. Maintenance to check heating system and install a radiator in small sitting room.</td>
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<tr>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
<td>Post-Holder(s)</td>
</tr>
<tr>
<td>Clinical Nurse Manager II to monitor</td>
<td>Achievable and Realistic</td>
<td>30/06/2020</td>
<td>Clinical Nurse Manager II</td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Staff to ensure windows are kept closed based on temperature. Sitting Room: Radium panels have been repaired and room is now heated to correct temperature.</td>
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<tr>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
<td>Post-Holder(s)</td>
</tr>
<tr>
<td>Clinical Nurse Manager II to monitor. Clinical Nurse Manager II to monitor and liaise with maintenance if issue re-occurs.</td>
<td>Achievable and Realistic</td>
<td>30/06/2020</td>
<td>Clinical Nurse Manager II</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000631</th>
<th>The minimisation of ligature points to the lowest practicable level, based on risk assessment, was not undertaken, 22(3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
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</table>
## Regulation 32: Risk Management Procedures

### Reason ID: 10000626

**Health and safety risks including fire risks were not identified, assessed, reported, treated, monitored, and recorded in the risk register.**

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<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Health and Safety Risks within the Approved Centre have been identified, assessed, reported, treated and monitored and are recorded in the risk register. CNM II's and nursing staff working in the Approved Centre have completed Training in Risk Management.</td>
<td>Audit</td>
<td>Achievable and Realistic</td>
<td>31/03/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The Risk Register is updated as an ongoing process by the CNM II and reviewed every 2 months at the Clinical Governance Meeting. Risk Management Training is ongoing.</td>
<td>Audit</td>
<td>Achievable and Realistic</td>
<td>31/03/2020</td>
</tr>
</tbody>
</table>

### Reason ID: 10000627

**The risk management procedures did not actively reduce the identified risks to the lowest level of risk. Structural risks, including ligature points, remained and were identified but there was no documented action plan to reduce, remove, or effectively mitigate these risks. Ligature point risks were not documented in the risk register.**

<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>Ligature Audit completed in 2019. Action Plan in place. See attached email with relevant details. Funding has been requested to remove ligatures.</td>
<td>Audit will be completed annually and Action Plan developed. Escalated to Catchment Management Team and is now on the Longford/Westmeath Risk Register.</td>
<td>Achievable and Realistic</td>
<td>30/06/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Funding is required and Maintenance to manage minor ligature issues as per action plan. Audit on an annual basis</td>
<td>Audit annually</td>
<td>Achievable and Realistic unless there is a delay in receiving the required Funding</td>
<td>30/06/2020</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.