St Ita’s Ward, St Brigid’s Hospital

ID Number: AC0016

2019 Approved Centre Inspection Report (Mental Health Act 2001)

St Ita’s Ward, St Brigid’s Hospital
Kells Road
Ardee
Co Louth

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

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor: HSE

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

Inspection Team: Siobhán Dinan, Lead Inspector
Martin McMenamin
Sarah Moynihan

Inspection Date: 12 – 14 March 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 28 – 31 August 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Thursday 29 August 2019

2019 COMPLIANCE RATINGS

REGULATIONS
Compliant: 3
Non-compliant: 6
Not applicable: 22

RULES AND PART 4 OF THE MENTAL HEALTH
Compliant: 4
Non-compliant: 3

CODES OF PRACTICE
Compliant: 1
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. Ita’s Ward was located within St. Brigid’s Hospital in Ardee. It was the last in-patient unit still functioning within the hospital campus. While the approved centre was registered for 20 beds, the number of beds in operation had decreased to eight at the time of this inspection. There had been no admissions since the last inspection and an active process of moving residents to community settings was in place.

In 2017, compliance with regulations, rules and codes of practice was 58%. There was a significant improvement in 2018 to 90% compliance. In 2019, compliance was 76%. Five compliances with regulations were rated 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 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 1 and the approved centre was compliant with Regulation 22: Premises at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. There were also proper facilities for the refrigeration, storage, preparation, cooking, and serving of food and a high standard of hygiene was maintained in food areas.
- All individual care plans included a risk management plan.
- Hazards were minimized in the approved centre, such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, as well as hard and rough surfaces.
- A ligature audit had been completed in the approved centre, indicating that ligature points were minimised to the lowest practicable level, based on an appropriate risk assessment.
However:

- The medication trolley in the approved centre was not locked at all times and secured in a locked room.
- Not all staff had up-to-date mandatory training in fire safety, Basic Life Support, the management of aggression and violence, Children First and the Mental Health Act 2001.

Appropriate care and treatment of residents

- Each resident had an individual care plan (ICP). A key worker was identified to ensure continuity in the implementation of a resident’s ICP. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. All ICPs identified the resident’s assessed needs, appropriate goals, the care and treatment required to meet the goals identified, and the resources required to provide the care and treatment. All ICPs were reviewed by the multi-disciplinary care plan in consultation with the resident on a six monthly basis.
- The therapeutic services and programmes provided by the approved centre were appropriate, evidence-based, and met the assessed needs of the residents. This was documented in residents’ ICPs.
- The service had introduced a social farming initiative to residents. Social farming is the practice of offering, on a voluntary basis, farming and horticultural participation in a farming environment as a choice to people who avail of a range of therapeutic day support services. The service was actively involved with the ‘Music in Mind’ initiative in the National Concert Hall. Each eight-week programme was tailored for each group and provided percussion and choral workshops to residents.

However:

- One resident did not have a physical examination within six months as scheduled.
- The six-monthly general health assessment records reviewed did not routinely include all of the requirements; family/personal history, Body Mass Index, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health were not included consistently in the five clinical files inspected.
- There was no documented evidence that all residents on antipsychotic medication had received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, or prolactin levels. Full records were not available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. Bloods identified as being required were ordered in the approved centre, but subsequently either not taken or the results were not placed into the clinical files.

Respect for residents’ privacy, dignity and autonomy
• The number of beds in operation in the approved centre had decreased since the last inspection enabling all residents to have single bedrooms.

• A separate visiting area was provided where residents could meet visitors in private, with two private rooms and also small alcoves with appropriate seating to allow comfort and privacy for visits.

• 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 in the approved centre.

• On inspection, it was observed that appropriately sized communal rooms were provided in the approved centre, and the premises was warm with appropriate ventilation. The unit was well maintained, both internally and externally.

• On inspection, the approved centre was observed as being clean, hygienic, and free from offensive odours.

• All residents’ records were secure, up to date, in good order, and were well constructed and no loose pages were observed. Clinical files were stored in a filing cabinet in a locked office.

However:

• The approved centre operated a closed-door policy with the result that residents had to request to enter and leave the ward.

**Human Rights**

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

**Responsiveness to residents’ needs**

• Scheduled recreational activities were provided by the approved centre and were appropriately resourced. Opportunities were provided for indoor and outdoor exercise and physical activity, on weekdays and during the weekend. Resident community meetings were held approximately monthly, where residents gave feedback and suggestions in relation to recreational activities within the approved centre.

• Residents were provided with written and verbal information on diagnosis and medications as well as a booklet about the approved centre.

• There was a robust complaints procedure in place.

However:
• Menus for those on special diets were limited and residents were receiving the same meal options for long periods. Staff reported to the inspection team that they were consistently serving the same food options to residents.

Governance of the approved centre

• St. Ita’s Ward was part of Laois/Offaly, Longford/Westmeath, Louth/Meath Community Healthcare, and was managed by the Louth Meath Mental Health Service (LMMHS).
• The executive management team and local management teams met on a monthly basis.
• There was a local Clinical Governance Committee and other rehabilitation service committees, which specifically dealt with management of services within the approved centre.
• All heads of discipline had received training on clinical risk management and each department escalated risks to the service risk register where appropriate. The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. There was evidence of risks being identified in the service and there being escalated to the risk register as appropriate.

However:

• The inspection team were informed of the recent fragmentation of the policy and audit development committee; this resulted in inefficiency in the policy and audit review and development process. Several policies were missing information and remained unchanged from the previous year’s inspection and some policies were out of date and in need of review.
• There were many deficits in areas relating to audit and analysis and it appeared that there has been minimal improvement since last year’s inspection. However, the inspection team were informed that the committee had been reformed and that improvements with policy and audit were a priority for the service.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The number of beds in operation in the approved centre had decreased since the last inspection enabling all residents to have single bedrooms.

2. The service had introduced a social farming initiative to residents. Social farming is the practice of offering, on a voluntary basis, farming and horticultural participation in a farming environment as a choice to people who avail of a range of therapeutic day support services.

3. The service were actively involved with the ‘Music in Mind’ initiative in the National Concert Hall. Each eight-week programme was tailored for each group and provided percussion and choral workshops to residents.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Ita’s Ward was located within St. Brigid’s Hospital in Ardee. It was the last in-patient unit still functioning within the hospital campus. While the approved centre was registered for 20 beds, the number of beds in operation had decreased to eight at the time of this inspection.

The approved centre was managed by the Rehabilitation Team which was based close by. There had been no admissions since the last inspection and an active process promoting the movement of residents to the community was in place. All residents had a history of medium to long-term care with an elderly age profile. All had been resident over six months. The approved centre operated a closed-door policy with the result that residents had to request to enter and leave the ward. The decrease in resident numbers had facilitated the provision of individual bedrooms to all residents.

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>20</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>8</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>2</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>8</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

St. Ita’s Ward was part of Midlands Louth, Meath, Longford, Westmeath Community Healthcare, and was managed by the Louth Meath Mental Health Service (LMMHS). The General Manager for Mental Health Services in Area 8 was the registered proprietor of the approved centre. There was an organisational chart in place. The governance structure for the Louth/Meath Mental Health Service was led by the Multi-disciplinary Executive Management Team (MEMT) which reported to the Lead in Mental Health for Laois/Offaly, Longford/Westmeath, Louth/Meath Community Healthcare area. The MEMT was responsible and accountable for the strategic and operational direction of the service. This management team structure provided a framework for bringing together clinical and non-clinical information from a wide range of sources to form an overview of the activities of the service to support governance and strategic management.

The executive management team and local management teams met on a monthly basis. Minutes were provided of a number of groups overseeing various aspects of governance, both throughout the service and in the approved centre specifically. Minutes of the MEMT and Area Clinical Governance Committee provided
evidence of an active governance process, which considered overall service development, compliance, service user complaints and feedback, policy strategy and health and safety strategy, staffing, training, and quality and patient safety issues including incidents. In addition, there was a local Clinical Governance Committee and other rehabilitation service committees, which specifically dealt with management of services within the approved centre. The minutes evidenced an active governance process through robust and active agendas with outcomes and actions allocated accordingly.

The inspection team were informed of the recent fragmentation of the policy and audit development committee; this resulted in inefficiency in the policy and audit review and development process. Several policies were missing information and remained unchanged from the previous year’s inspection and some policies were out of date and in need of review. There were many deficits in areas relating to audit and analysis and it appeared that there has been minimal improvement since last year’s inspection. However, the inspection team were informed that the committee had been reformed and that improvements with policy and audit were a priority for the service.

The service facilitated service user and public involvement and participation through the facilitation of involvement at all stages of policy and service development, delivery and evaluation. Representatives from the consumer panel and service user/carer’s representatives were involved in a number of the service’s committees. Service user input to each department was also facilitated by the ethos of engagement with advocacy within the approved centre.

All heads of discipline had received training on clinical risk management and each department escalated risks to the service risk register where appropriate. Relevant staff were trained in the identification, assessment, and management of risk and health and safety risk management. Training records evidenced that not all clinical staff were trained in individual risk management processes and that all staff were not trained in incident reporting and documentation. The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Responsibilities in relation to risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk register was reviewed at the management team clinical governance group on a quarterly basis. There was evidence of risks being identified in the serviced and there being escalated to the risk register as appropriate. All incidents in the approved centre were recorded and risk rated in a standardised format. The quality and patient safety manager reviewed incidents for any trends or patterns occurring in the services to identify opportunities for improving risk management processes.

The Mental Health Commission compiled information received from each of the heads of discipline operating in St. Ita’s ward prior to the inspection. The majority of the heads of discipline were based on the St. Brigid’s Hospital campus, which was in close proximity to the approved centre and enabled them to fulfil their management role on-site. Defined lines of responsibility were evident in all disciplines. Each head of discipline met with staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. Staff supervision was facilitated within each department. All heads of discipline identified strategic aims for their teams and discussed potential operational risks with their departments which included difficulties in; recruiting and retaining staff resulting in an over reliance in the use of agency staffing; the inability of staff to maintain mandatory training levels; temporary staff vacancies not being filled and a lack of budget to support Continuous Professional Development (CPD) for staff. These were agenda items at senior management 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>
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</thead>
<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
<td>X Moderate</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X Low</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X Low</td>
<td>X Low</td>
<td>X Low</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>
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<tbody>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
</tbody>
</table>
**4.3 Areas that were not applicable on this inspection**

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

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

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

Two residents met with the inspection team. Both residents were satisfied with their treatment and care within the approved centre and stated that staff were helpful, friendly, and kind. Residents were happy with the selection of activities available to them. They were complimentary of the food and expressed having a good selection of food to choose from. Both residents were aware of the individual care plan process. They did not raise any issues of concern which required the attention of management. In addition, a family member of a resident met with the inspection team. They expressed satisfaction regarding their relative’s care within the approved centre and with their engagement with the staff of the approved centre. No resident returned a questionnaire based on the information leaflets distributed.
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:

- Interim Business Manager
- Executive Clinical Director
- Interim General Manager
- Interim Area Director of Nursing
- Area Lead for Mental Health Engagement
- Acting Assistant Director of Nursing
- Quality & Risk Manager
- Consultant Psychiatrist in Rehabilitation
- Clinical Nurse Manager 2
- Clinical Nurse Manager 1
- Senior Occupational Therapist
- Principal Social Worker
- Principal Clinical Psychologist

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.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The identifiers 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. Sticker alerts were used to alert staff to the presence of residents with the same or a similar name.

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

NON-COMPLIANT

<table>
<thead>
<tr>
<th>Quality Rating</th>
<th>Requires Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Rating</td>
<td>LOW</td>
</tr>
</tbody>
</table>

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Menus were reviewed by a dietitian, speech and language therapist and catering manager annually, and reviewed by the catering manager quarterly. Residents had at least two choices for meals: two choices were available each day for breakfast, dinner, dessert, tea and supper. There were two water dispensers on the corridor of the approved centre, ensuring residents had access to safe, fresh drinking water in easily accessible locations. All residents were given a baseline assessment by the dietitian. Those with dietary and nutritional needs were reviewed more frequently by a dietitian as required and nutritional issues were documented in the individual care plans.

Residents on special diets were not provided with a variety of wholesome and nutritious food, menus for those on special diets were limited and residents were receiving the same meal options for long periods. Staff reported to the inspection team that they were consistently serving the same food options to residents.

The approved centre was non-compliant with this regulation because residents on a special diet were not provided with food that involved an element of choice, 5(2).
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 October 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of food preparation, handling, storage, distribution, and disposal controls.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

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

Evidence of Implementation: There was suitable and sufficient catering equipment observed in the main kitchen and approved centre’s kitchen. There were also proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Residents were provided with suitable and sufficient crockery and cutlery to address their specific needs. A high standard of hygiene was maintained in relation to the storage, preparation and disposal of food and related refuse, as overseen by the catering manager and household staff.

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 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 all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Clothing was laundered on site, and a washing machine was available in the unit if residents wished to do their own washing as part of independent living skills. Residents were provided with emergency personal clothing that was appropriate to the resident and considered the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours. At the time of inspection, no residents were prescribed night attire during daytime hours.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in March 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: A resident’s personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident’s monies, valuables, personal property and possessions, as necessary. The resident was entitled to bring personal possessions with him/her, the extent of which was agreed at admission. All lodgements and transactions were recorded by either two nurses or a nurse and resident account holder, ensuring a clear trail of transactions. Where any money belonging to a resident was handled by staff, signed records of the staff issuing the money was retained, and all personal accounts were stored in an individual resident bag with their name clearly labelled. Residents were supported to manage their own property, in keeping with the ethos of rehabilitation.

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

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

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

Evidence of Implementation: Scheduled recreational activities were appropriate to resident needs in the approved centre and a recreational activity log was maintained. The recreational activities provided by the approved centre were appropriately resourced. Opportunities were provided for indoor and outdoor exercise and physical activity. Information was provided to residents in an accessible format, which was appropriate to his/her individual needs. The approved centre provided access to recreational activities on weekdays and during the weekend. Resident community meetings were held approximately monthly, where residents gave feedback and suggestions in relation to recreational activities within the approved centre. Residents were free to choose whether to participate and their decisions were respected and documented.

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 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 March 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 insofar as was practicable. There were facilities provided within the approved centre for residents’ religious practices. Residents had access to multi-faith chaplains. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values. Any specific religious requirements relating to the provision of services, care and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practices in accordance with his/her 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 in relation to visits. The policy was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: There was clear signage regarding visiting at the approved centre entrance door, and visiting regulations were identified in the wards information booklet. Visiting times were appropriate, reasonable, and consistent with normal visiting hours. A separate visiting area was provided where residents could meet visitors in private, with two private rooms and also small alcoves with appropriate seating to allow comfort and privacy for visits. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. The visiting area was suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 12: Communication

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in March 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 communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were 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 and phone, but not internet or e-mail. Individual risk assessments were deemed inappropriate in relation to any risks associated with their external communication. No resident was considered to require limitation to their communication.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the implementation of resident searches. The policy for searches of residents’ person and belongings was last reviewed in September 2017 and in April 2018 for Alcohol, Illicit Substances and Non-Prescribed Medications. The policies and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: Since no searches had been undertaken in the approved centre since the last inspection, the Monitoring pillar of this Regulation was non-applicable.

Evidence of Implementation: Since no searches had been undertaken in the approved centre since the last inspection, the evidence of implementation pillar of this Regulation was non-applicable.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was due for review in May 2019. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Systems analysis was not undertaken as this was not deemed applicable. There had not been any end of life care in the approved centre since the last inspection, which meant a documented analysis was not applicable.

Evidence of Implementation: The sudden death of a resident was managed in accordance with legal requirements. The sudden death of a resident was managed in accordance with the resident’s religious and cultural practices, with dignity and propriety. Support was given to other residents and staff following a resident’s death. All deaths of residents, including resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission with 48 hours of the death.

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 February 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 not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: All ICPs inspected in the approved centre were a composite set of documents, included space and sections for goals, treatment, care and resources required, and also included spaces and sections for reviews. In addition, ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. A key worker was identified to ensure continuity in the implementation of a resident’s ICP.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. All ICP identified the resident’s assessed needs, appropriate goals and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICPs also identified the resources required to provide the care and treatment identified.

All ICPs were reviewed by the MDT in consultation with the resident on a six monthly basis. ICP’s were updated following review, as indicated by the resident’s changing needs, condition, circumstances, and goals. There was evidence that each resident was offered a copy of their ICP, including any reviews. All ICPs included a risk management plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring 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 2018. The policy addressed requirements of the Judgement Support Framework, with the exception of assessing residents as to the appropriateness of services and programmes, including risk.

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 not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents. This was documented in residents’ individual care plans. Also, the therapeutic services and programmes were evidence based and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. A horticulturist was employed to facilitate a garden group with the occupational therapist, and local farmers participated in social farming groups. The approved centre was also actively involved with the ‘Music in Mind’ initiative in the National Concert Hall.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. Where a resident required a therapeutic service or programme that was not provided internally such as chiropody, physiotherapy, and speech and language therapy, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was 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 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in February 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 transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not 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 for specialised treatment in another healthcare facility was examined. An assessment of the resident prior to transfer was completed, however a risk assessment was not completed. A resident transfer form was completed and was provided to the receiving facility. There was no evidence that a letter of referral, including list of current medications was issued as part of transfer documentation.

Full and complete written information for the resident was not transferred when he/she moved from the approved centre to another facility. Communications between the approved centre and the receiving facility were not fully documented or followed up with a written referral.

The approved centre was non-compliant with this regulation because the approved centre did not ensure that all relevant information about the resident was provided to the receiving facility, 18(1).
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 general health policy was last reviewed in March 2018. The medical emergencies policy was last reviewed in September 2015. The policies and procedures addressed requirements of the Judgement Support Framework, with the exception of the referral process for residents’ general health needs.

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

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with individual care plans. All residents were registered with a General Practitioner (GP), ensuring referral to external health services as required. Residents had access to national screening programmes that were available according to age and gender, including retina check and bowel screening. Residents had access to smoking-cessation programmes and supports.

Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, but not less than every six months. One resident did not have a physical examination within six months as scheduled. The six-monthly general health assessment records reviewed did not routinely include all of the requirements; family/personal history, Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health were not included consistently in the five clinical files inspected.

There was no documented evidence that all residents on antipsychotic medication had received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, or prolactin levels. Full records were not available demonstrating residents’ completed general health checks and associated results,
including records of any clinical testing. Bloods identified as being required were ordered in the approved centre, but subsequently either not taken or the results were not placed into the clinical files.

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

a) The six-monthly general health assessment records and associated tests were not fully completed; residents’ family/personal history, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health were not included in all clinical files inspected, 19 (1)(b).

b) There was no documented evidence that residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, or prolactin levels, 19 (1)(b).

c) One resident's general health needs were not assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, 19 (1)(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There was evidence of the policy being implemented in relation to the provision of information to residents and their representatives at admission, including housekeeping arrangements, including arrangements for personal property and mealtimes; visiting times and arrangements; details of relevant advocacy and voluntary agencies; and residents’ rights. Residents were provided with the details of their multi-disciplinary team (MDT), contained in the information booklet.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side effects.

Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in February 2018. 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 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 addressed by their preferred names, and staff members interacted with residents in a respectful manner. Staff were discreet when discussing residents’ condition or treatment needs. Residents wore clothing that respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. 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 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 training and education 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 its premises, which was last reviewed in August 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: On inspection, it was observed that appropriately sized communal rooms were provided in the approved centre, and the premises was warm with appropriate ventilation. Private and communal areas were suitably sized to mitigate against excessive noise and acoustics. External signage indicating the location of the unit was inadequate. However, appropriate signage and sensory aids were provided to support residents’ orientation needs. Hazards were minimized in the approved centre, such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, as well as hard and rough surfaces.

A ligature audit had been completed in the approved centre, indicating that ligature points were minimized to the lowest practicable level, based on an appropriate risk assessment. The unit was well maintained, both internally and externally. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of various types of assistive equipment. Records were maintained in this regard.
On inspection, the approved centre was observed as being clean, hygienic, and free from offensive odours. There were three showers and seven toilets in four locations around the premises, resulting in an adequate and sufficient number for the resident population. All resident bedrooms were appropriately sized to address the resident’s needs. Some of these rooms were formerly multi-occupancy rooms.

Rooms were centrally heated with pipe work and radiators were guarded or guaranteed to have surface temperatures no higher than 43°C. Heating could not be safely controlled in the resident’s own room, in compliance with the relevant health and safety guidance and building regulations.

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 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework, with the exception of the process for medication reconciliation.

Training and Education: Not all nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff, as well as pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff, as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. 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: All entries in the MPAR were legible, and written in black, indelible ink. Medication was generally reviewed every four months, falling into the minimum six-monthly threshold. Prescriptions were not altered where a change was required, and where there was an alteration in the medication order, the relevant medical practitioner had rewritten the prescription. All medications, except those for self-administration, were administered by a registered nurse or the appropriate medical practitioner, as required. Medicinal products were administered in accordance with the directions of the assigned prescriber, and, in addition, any advice was provided by the resident’s pharmacist regarding the appropriate use of the product in question. Expiration dates of medications were checked prior to administration, and expired medications were not administered to the receiving resident.

Medication was stored in the appropriate environment as indicated on the label or packaging, or as advised by the pharmacist. Areas in which the medications were stored were found to be free from damp and mould, generally clean, free from litter, dust, pests, and free from spillage or breakage, and food and drink was not stored in areas used for the storage of medication.

A record of all medications administered to the resident was not kept. The medication trolley in the approved centre was not locked at all times and secured in a locked room.

The approved centre was non-compliant with this regulation for the following reasons:
a) The medication trolley was not locked at all times, 23 (1).
b) A record of all medication administered to the resident was not maintained, 23 (1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The policies were last reviewed in March 2018, and February 2019. The policies and the safety statement included all of the requirements of the Judgement Support Framework.

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

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

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

The approved centre was compliant with this regulation.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Monitoring: The implementation and effectiveness of the staff-training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: On inspection, the numbers and skill mix of staffing were found to be sufficient to meet resident needs. The staff rota evidenced that an appropriately qualified staff member was on duty and in charge at all times, and this was documented. Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff-training plan. All staff training was documented.

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

There was no written staffing plan in the approved centre. Staff training records indicated that significant deficits in mandatory training were evident, including training on fire safety, Basic Life Support,
management of violence and aggression, the Mental Health Act 2001, and Children First. Not all staff were up to date with required training in this regard.

The following is a table of staff mandatory training levels in the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (16)</td>
<td>10</td>
<td>63%</td>
<td>6</td>
<td>38%</td>
<td>6</td>
</tr>
<tr>
<td>Consultant Psychiatrist (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Medical (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist (1)</td>
<td>1</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist (1)</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>1</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></td>
<td>CNM1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MTA</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>St. Ita’s Ward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Variable</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Variable</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Variable</td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in June 2018. The policy/policies and procedures addressed all of the requirements of the Judgement Support Framework, with the exception of the following:

- Record review requirements.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were not included in the review process. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All residents’ records were secure, up to date, in good order, and were well constructed with relevant subsections and an index page. In addition, they were used in accordance with national guidelines and relevant legislative requirements. During the inspection of clinical files, resident records were found to be reflective of the residents’ current status and the care and treatment being provided. Each clinical file contained an index page resulting in a logical sequence, and outlined subsections, and the document to be stored within the subsections. Records were maintained in good order, and no loose pages were observed in this regard.

Clinical files were stored in a locked office within a filing cabinet. This prevented loss, destruction, tampering, and unauthorised access or use of pertinent records. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre. The approved centre did not maintain a record of all signatures used in the resident record.
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 28: Register of Residents

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

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

### INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
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. It included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The format of policies and procedures was standardized.

The operating policies and procedures in relation to two regulations had not been reviewed within the past three years:

- Regulation 19: Responding to Medical Emergencies.
- Regulation 31: Complaints Procedures.

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

The approved centre was non-compliant with this regulation because not all written operational policies and procedures for the approved centre were reviewed within the recommended 3-year period.
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 of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident’s individual care plan.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints. The policy was out of date and was last reviewed in January 2016. The policy addressed all of the requirements of the Judgement Support Framework, including the following processes:

- Managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services or care.
- Treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: 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 noticeboards, and it was detailed within the resident’s information booklet. 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, by telephone, and through complaint, feedback, or suggestion forms.
All complaints were handled promptly, appropriately and sensitively. The quality of the service, care and treatment of a resident did not appear to be adversely affected by reason of the complaint being made. All complaints were dealt with by the nominated person and recorded in the complaints log. The complainant’s satisfaction or dissatisfaction with the investigation findings was documented.

Minor complaints were documented separately. 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 and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in May 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, with the exception of capacity risks relating to the number of residents in 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. Not all clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

**Evidence of Implementation:** The person with responsibility for risk was identified and known by all staff, and the risk management procedures actively reduced identified risks to the lowest practicable level. Clinical risks were found to have been identified, assessed, treated, reported and monitored, and clinical risks were documented in the risk register, as appropriate. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation. Remaining ligature points in the approved centre were assessed as not being a risk for the current cohort of residents.

Corporate risks were identified, assessed, treated, reported and monitored by the approved centre, and the approved centre implemented a plan to reduce risks to residents while any works on the premises were ongoing. The requirement for the protection of vulnerable adults within the approved centre were appropriate and implemented as required. The National Incident Management System (NIMS) was utilised to ensure all incidents were recorded and risk rated in a standardised format.
The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. Information was provided anonymously at resident level in this regard. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. In addition, the emergency plan incorporated evacuation procedures.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, risk of self-harm, and in conjunction with medication requirements or administration. Individual risk assessments were not completed prior to and during resident transfer and discharge.

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 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 within the approved centre.

The approved centre was compliant with this regulation.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
Part 4 of the Mental Health Act 2001: Consent to Treatment, was not applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to transfer and discharge. There was no policy on admission.

Transfer: The transfer policy, which was last reviewed in February 2018, included all of the policy-related criteria for this code of practice.

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

Training and Education: There was documentary evidence that relevant staff had read and understood the transfer policy. However, not all staff had signed the equivalent log for the discharge policy.

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

Evidence of Implementation:

Admission: This section was not applicable, as the approved centre was no longer admitting residents.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: The discharge plan in the approved centre included the estimated date of discharge, evidenced by the clinical file, and documented communication with the relevant documented communication with relevant health professionals. Discharge was coordinated by a key worker, and a preliminary discharge summary was sent to the relevant health professionals within three days. A follow-up plan and a reference to early warnings signs of relapse and risks were also included in the discharge plan.

On inspection, a pre-discharge meeting was evidenced within the clinical file. Consequently, the last Multidisciplinary Team (MDT) / Individual Care Plan (ICP) updated was evidenced to be in October 2018. The discharge assessment did not address the following: psychiatric and psychological needs, current mental state examination, or informational needs. A comprehensive risk assessment and risk management plan had not been completed.

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

a) A written admission policy was not in place in accordance with the guidance contained in this code, 4.1
b) An audit of the implementation of and adherence to the transfer and discharge policy was not evidenced, 42.1 (c)
c) A pre–discharge meeting was not evidenced within the clinical file, 34.4
d) The discharge assessment did not address the points specified in the Mental Health Commission Code of Practice, issued pursuant to Section 33 (3) (e) of the Mental Health Act, 2001, 35.1
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 5 Food and Nutrition

<table>
<thead>
<tr>
<th>Reason ID : 10000196</th>
<th>Residents on a special diet were not provided with food that involved an element of choice, 5(2).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feedback from Residents on an individual basis and through the fortnightly Community Ward meetings. Menu discussed with Catering Dept. Menu is changed every 5 weeks.</td>
<td>Food Satisfaction Audit</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>CNM2 Catering Manager</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing review of menu / liaison with Catering Dept. Menu was reviewed and approved by Community Dietician.</td>
<td>Observation Feedback from Food and Nutrition Committee</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>CNM 2 Dietician Catering Manager</td>
</tr>
</tbody>
</table>
Regulation 18: Transfer of Residents

The approved centre did not ensure that all relevant information about the resident was provided to the receiving facility, 18(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review of the transfer checklist form carried out to ensure all relevant information about the resident is provided at the time of transfer including risk assessment and transfer letter.</td>
<td>Transfer audit completed and recommendations noted</td>
<td>Achievable</td>
<td>28/06/2019</td>
<td>CNM2 Social Worker</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitoring of all transfers.</td>
<td>Audit of transfer check list</td>
<td>Achieveable</td>
<td>28/06/2019</td>
<td>CMN2</td>
</tr>
</tbody>
</table>
### Regulation 19 General Health

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000198</td>
<td>The six-monthly general health assessment records and associated tests were not fully completed; residents family/personal history, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health were not included in all clinical files inspected, 19 (1)(b).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>All 6 monthly general health checks completed on all residents.</td>
<td>General Health Audit completed</td>
<td>Achievable</td>
<td>31/05/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Continuous monitoring of general health assessments.</td>
<td>General Health Audit completed</td>
<td>Achievable</td>
<td>31/05/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000199</td>
<td>There was no documented evidence that residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, or prolactin levels, 19 (1)(b).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>New template devised and implemented to incorporate glucose regulation, blood lipids, an electrocardiogram, or prolactin levels.</td>
<td>6 monthly audit to be completed to ensure compliance</td>
<td>Achievable</td>
<td>31/05/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>New Template devised and implemented.</td>
<td>6 monthly audit</td>
<td>Achievable</td>
<td>31/05/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10000200</td>
<td>One resident's general health needs were not assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, 19 (1)(b).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>General Health assessment completed.</td>
<td>Record of assessment in clinical file</td>
<td>Achieveable</td>
<td>29/03/2019</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------</td>
<td>---------------------------------------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Record maintained in Ward office when general health assessment due.</td>
<td>Checklist available in Ward Office</td>
<td>Achievable</td>
<td>30/04/2019</td>
</tr>
</tbody>
</table>
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>The medication trolley was not locked at all times, 23(1).</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All staff read the Medication Policy regarding safe storage of medication.</td>
<td>Signature List</td>
<td>Achievable</td>
<td>31/05/2019</td>
<td>CNM2</td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>No further incidents noted.</td>
<td>Monthly Quality Care Nursing Metrics</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>ADON</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spot checks by Adon as well as monthly checks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>A record of all medication administered to the resident was not maintained, 23(1).</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Daily monitoring of medication administration records.</td>
<td>Spot checks by ADON</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>CNM1, CNM2</td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Spot checks by ADON.</td>
<td>Monthly Quality Care Nursing Metrics</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>ADON</td>
<td></td>
</tr>
</tbody>
</table>
Regulation 26: Staffing

Reason ID: 10000203

<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>Extra training courses made available for staff to complete mandatory training. All staff now trained in PMAV. High levels of mandatory training in Children First and Mental Health Act now achieved.</td>
<td>Individual quarterly reports</td>
<td>Achievable</td>
<td>30/09/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Monitoring of training reports</td>
<td>Individual quarterly reports</td>
<td>Achievable</td>
<td>30/09/2019</td>
</tr>
</tbody>
</table>
### Regulation 29: Operating Policies and Procedures

<table>
<thead>
<tr>
<th>Reason ID : 10000205</th>
<th>Not all written operational policies and procedures for the approved centre were reviewed within the recommended 3-year period.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Policies and Procedures which required updating have been updated.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Policies and Procedures which required updating have been updated.</td>
<td>Annual Audit</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ongoing review and updating of policies and procedures as required.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Ongoing review and updating of policies and procedures as required.</td>
<td>Annual Report</td>
</tr>
</tbody>
</table>
## Code of Practice on Admission, Transfer and Discharge to and from an approved centre

### Reason ID: 10000192

A written admission policy was not in place in accordance with the guidance contained in this code, 4.1. An audit of the implementation of and adherence to the transfer and discharge policy was not evidenced, 42.1 (c).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of Policies and Procedures</td>
<td>A written admissions policy is in place for St Ita's Ward.</td>
<td>Achievable</td>
<td>29/03/2019</td>
<td>Dr Catherine McDonough, Consultant Psychiatrist</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of policies and procedures</td>
<td>A written policy is in place.</td>
<td>achievable</td>
<td>29/03/2019</td>
<td>Dr Catherine McDonough, Consultant Psychiatrist</td>
<td></td>
</tr>
</tbody>
</table>

### Reason ID: 10000194

A pre-discharge meeting was not evidenced within the clinical file, 34.4.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer audit compiled and recommendations noted</td>
<td>Monitoring of all transfers and discharges within the approved centre.</td>
<td>Achievable</td>
<td>28/06/2019</td>
<td>CNM2 Social Worker</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer audits</td>
<td>Transfer and discharge checklist reviewed and amended where necessary to incorporate evidence of discharge meeting.</td>
<td>Acheiveable</td>
<td>28/06/2019</td>
<td>CNM2 Social Worker</td>
<td></td>
</tr>
</tbody>
</table>

### Reason ID: 10000195

The discharge assessment did not address the points specified in the Mental Health Commission Code of Practice, issued pursuant to Section 33 (3) (e) of the Mental Health Act, 2001, 35.1.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Discharge checklist reviewed and requirement for pre-discharge assessment and associated requirement included in discharge checklist.</td>
<td>Discharge Audit</td>
<td>Achieveable</td>
<td>30/09/2019</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Monitoring of discharges in accordance with the checklist.</td>
<td>Discharge Audit</td>
<td>Achieveable</td>
<td>27/09/2019</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.