St Michael's Unit, Mercy University Hospital

ID Number: AC0029

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type: Acute Adult Mental Health Care Psychiatry of Later Life

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor: HSE

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

Inspection Team: Sarah Moynihan, Lead Inspector
Carol Brennan-Forsyth
Martin McMenamin
Noeleen Byrne

Inspection Date: 24 – 27 September 2019

Previous Inspection Date: 11 – 14 December 2018

Inspection Type: Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Monday 09 March 2020

2019 COMPLIANCE RATINGS

- REGULATIONS: 8 compliant, 2 non-compliant, Not applicable
- RULES AND PART 4 OF THE MENTAL HEALTH: 4 compliant, 2 not applicable
- CODES OF PRACTICE: 1 compliant, 1 non-compliant
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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Inspector of Mental Health Services

Dr Susan Finnerty

1.0 Inspector of Mental Health Services – Review of Findings

In brief

St. Michael’s Unit was situated in Cork city centre, on the first floor of the Mercy University Hospital. The 50-bedded unit contained two wards: acute (32 beds) and sub-acute wards (18 beds). There was no direct access to outside space for residents and the approved centre had limited internal space. St. Michael’s Unit provided acute inpatient care to the following areas: City North East, City North West, Blarney/Macroom, Cobh, Glenville, and Middletown/Youghal. Each area had an individual clinical team that worked across the approved centre and the community. An Old Age Psychiatry clinical team also worked within the approved centre.

There was no improvement in compliance with regulations, rules and codes of practice since 2017. Compliance was 71% in 2017; 79% in 2018 and 71% in 2019. Non-compliance with Regulation 21 Privacy and Regulation 22 Premises were rated critical in 2019. Ten 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 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was in breach of Condition 1 and was non-compliant with Regulation 21: Privacy and Regulation 22: Premises at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, cooking and service of food as well as suitable and sufficient catering equipment. Hygiene was maintained to support food safety requirements and catering areas and associated catering food safety equipment were appropriately cleaned.
- Medication was ordered, stored and administered in a safe manner. Apart from the omission of one medication discontinuation date, medication prescription were also satisfactory.
• Structural risks, including ligature points, were not removed; however, they were effectively mitigated. Ligature works were on-going. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

However:

• Not all health care professionals were documented as having been trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001, or Children First.

Appropriate care and treatment of residents

• Each resident had an individual care plan following a comprehensive assessment of needs. All, bar one ICP, had multidisciplinary input and all were developed with the resident.
• The provision of therapeutic services and programmes was excellent. The therapy department facilitated multiple rolling groups. Groups run on a rolling basis included relaxation, mindfulness and peer support groups. Art therapy was delivered by an art therapist twice weekly. Other groups in the weekly schedule included, but were not limited to: problem solving group; social group, which were led by an occupational therapist; working towards discharge group; anxiety management group; a healing with compassion group; cooking group, craft group, and; an exercise group.
• The six-monthly general health assessments that had been carried out documented: a physical examination; family and personal history; Body Mass Index, weight, and waist circumference; blood pressure, smoking status; nutritional status; medication review, and; dental health. For residents on anti-psychotic medication there was an annual assessment of their glucose regulation, blood lipids, prolactin, and an electrocardiogram.

However:

• One of the clinical files indicated that a general health assessment had not been completed within the required six months.

Respect for residents’ privacy, dignity and autonomy

• There was a visitor’s room where residents could meet their visitors in private.
• All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or any other identifiable information. Residents were facilitated to make private phone calls.
• There was a cleaning schedule implemented within the approved centre.
• Searches were carried out with due regard for the residents’ privacy, dignity and gender.

However:
• Two 2-bedded rooms within the sub-acute unit were not of an adequate size to ensure residents’ privacy and dignity.
• The residents’ relaxation and recreational areas were limited and residents had no access to protected outside space. Due to this, the environment was restrictive in nature. Staff put great effort and imagination into compensating for the environmental constraints.
• Not all residents had access to personal space within their bedrooms. There was no quiet space available to residents within the approved centre. The sitting room in the sub-acute area acted as a thoroughfare to the recreational room and was observed to be noisy at times. Appropriately sized communal rooms were not provided as the sitting room in the sub-acute unit was too small for the number of residents in the unit. There was no sitting room in the acute unit of the approved centre; instead, a lounge area with seating was situated in front of the nurse’s station.
• Sufficient spaces were not provided for residents to move about as there was no outdoor space. Appropriate signage and sensory aids were not provided to support resident orientation needs.
• The approved centre was not kept in a good state of repair internally or externally and there was no programme of general or decorative maintenance. Mould was observed on the ceiling and floors of showers and there was chipped paint on many doors. Some improvements were evident regarding general maintenance, however there was no maintenance plan. A number of ceiling tiles were missing and floors were badly stained and engrained with dirt.
• A smell of cigarette smoke was noted in the approved centre during each day of the inspection.
• Adequate resources were not provided for tribunals as there was no dedicated tribunal room. Instead, the approved centre used the Green room mainly and the occupational therapy (OT) room occasionally for tribunals. The OT room had paint on the table, floor and sink.

Responsiveness to residents’ needs

• The approved centre menus were approved by a dietician to ensure nutritional adequacy and food, including modified consistency diets, was presented in a manner that was attractive and appealing. Residents had at least two choices for meals.
• Recreational activities were available on weekends and weekdays and included darts, air hockey, table tennis, board games, gym equipment, books, and DVDs. Individual risk assessments were completed for residents as deemed appropriate. Opportunities were provided for indoor and outdoor exercise and physical activity: walks and visits to the coffee shop were arranged daily.
• There was excellent written information provided about the approved centre and residents’ diagnoses and medication.
• There was a robust complaints procedure in place.

Governance of the approved centre

• St. Michael’s Unit, Mercy University Hospital was part of the North Lee Mental Health Services which was part of the wider Cork Kerry Community Healthcare Organisation. St. Michaels Unit was governed by the North Lee Mental Health Services Senior Management Team.
- The North Lee Policies Procedures, Protocols and Guidelines (PPPGs) group provided a multi-disciplinary approach to policy development, review, approval, and dissemination.
- Multiple non-mandatory training courses were available to staff and management supported and facilitated higher education programmes. Numerous staff had undertaken postgraduate courses in both clinical and managerial fields of study.
- There was an emerging culture of implementing quality improvement audit tools to monitor and evaluate standards of care. There was an audit cycle in place and, therefore, the benefits of re-auditing were captured and audit results were monitored by the Audit Committee which fed into the North Lee Mental Health Services Quality and Safety Committee.
- The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE’s ‘Comment, Compliment or Complaint’ process and community meetings situated in the approved centre.

However:

- Not all disciplines had formal structures and processes in place for measuring and encouraging staff performance and personal development. The formal arrangements and availability of clinical supervision varied across disciplines.
- There was no annual staff training needs analysis or plans completed. Records indicated that not all health professionals had up-to-date mandatory training.
- The approved centre’s registered proprietor held overall responsibility for the risk management process. The St. Michael’s Unit risk register was monitored and maintained by the Incident Review Group which reportedly met every three months. Members of the Incident Review Group consist of the Assistant Director of Nursing (ADON), Clinical Nurse Manager III and the Clinical Director. This group did not appear to facilitate a direct multi-disciplinary team approach in managing the approved centre’s risk register.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The Cork/Kerry Six-Monthly Physical Examination form had been reviewed, updated and implemented in St. Michael’s Unit in March 2019.

2. A Cork/Kerry Restraint Management Booklet had been applied in St. Michael’s Unit in July 2019.

3. A Cork/Kerry Falls Risk Assessment had been formulated and employed in St. Michael’s Unit in September 2019.

4. A pathway for the Acute Management of Eating Disorders had been formulated for residents presenting to the Mercy Emergency Department, which included the process for admission to St. Michael’s Unit.
3.1 Description of approved centre

St. Michael’s Unit was situated near the river Lee, in Cork city centre. The 50-bedded unit contained two wards and was based on the first floor of the Mercy University Hospital. The two wards were not officially named, but instead referred to as the acute and sub-acute wards. The acute ward contained 18 beds and the sub-acute ward had 32 beds. St. Michael’s Unit provided inpatient care to the following areas: City North East, City North West, Blarney/Macroom, Cobh, Glenville, and Middletown/Youghal. Each area had an individual clinical team that worked across the approved centre and the community. An Old Age Psychiatry clinical team also worked within the approved centre.

Access in and out of the main building and to the approved centre was controlled and monitored by a security guard, who was positioned at the main entrance of the unit. Due to the city centre location of the approved centre, parking was limited. The unit’s décor and soft furnishings were minimal and the premises was in need of updating. Although painting was underway at the time of inspection, numerous floor and ceiling areas were worn, stained, and in need of replacing.

The approved centre contained single bedrooms, double bedrooms, and dormitory rooms. Two 2-bedded rooms within the sub-acute unit were remarkably small and not of an adequate size to ensure residents’ privacy and dignity. The unit’s activities areas comprised of a dining room, an occupational therapy kitchen, an occupational art room, an activities room, a small gym, and a multi-purpose consultation room. On the sub-acute unit, there was a small sitting room with a conservatory attached; however, due to on-going issues with smoking, the conservatory had, at times, been locked from 17:00 onwards. The acute unit had a lounge area with chairs and a TV in front of the nurse’s station. The residents’ relaxation and recreational areas were limited and residents had no access to protected outside space. Due to this, the environment was restrictive in nature. Staff put great effort and imagination into compensating for the environmental constraints.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>50</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>43</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Number of wards of court</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>9</td>
</tr>
<tr>
<td><strong>Number of patients on Section 26 leave for more than 2 weeks</strong></td>
<td>0</td>
</tr>
</tbody>
</table>
3.2 Governance

St. Michael’s Unit, Mercy University Hospital was part of the North Lee Mental Health Services. North Lee was a subsection of Cork Mental Health Services, which was part of the wider Cork Kerry Community Healthcare Organisation. St. Michaels Unit was governed by the North Lee Mental Health Services Senior Management Team. Numerous sub-committees and working groups fed into the North Lee Senior Management Team, some of which included; the North Lee Quality and Safety Committee; St. Michaels Unit Delayed Discharge Group; Nurse Management Group; North Lee Policies Procedures, Protocols and Guidelines Committee; Incident Review Group; Cork Judgement Support Framework (JSF) and Best Practice Guidance Committee; St. Michael’s Audit Committee; Drugs and Therapeutic Committee, and; the Consultant Group. A multi-disciplinary approach was fostered within the majority of governance and clinical care structures; however, the Cork JSF and Best Practice Guidance Committee was nurse led, and the Incident Review Group was nursing and medical led, despite these groups having a multi-disciplinary remit. Not all of these committees’ purpose, structures, responsibilities, and reporting relationships were well defined, as outlined in the governance of risk paragraph below.

There was an induction programme for new staff and they underwent the HSE probation process. The service used the standard HSE induction checklists. Not all disciplines had formal structures and processes in place for measuring and encouraging staff performance and personal development. The formal arrangements and availability of clinical supervision varied across disciplines. There was no annual staff training needs analysis or plans completed. Records indicated that not all health professionals had up-to-date mandatory training. Reportedly, the main barriers for staff not achieving the required mandatory training were low staffing levels and the prioritisation of clinical demand over training attendance. Considering there was a prominent smoking issue on the unit combined with the physical structure and locality of the unit, it was a remarkable and acknowledged concern for governance that less than 50% of nursing staff had completed fire safety training. Multiple non-mandatory training courses were available to staff and management supported and facilitated higher education programmes. Numerous staff had undertaken postgraduate courses in both clinical and managerial fields of study.

The North Lee Policies Procedures, Protocols and Guidelines (PPPGs) group provided a multi-disciplinary approach to policy development, review, approval, and dissemination; however, the committee’s remit was in the process of changing as the wider Cork Kerry PPPGs was developing, reviewing, approving, and disseminating service-wide policies. These service-wide policies required the appropriate input and adaptation from the North Lee PPPGs group prior to implementation. At the time of inspection, the North Lee PPPGs group had given feedback on six pending service-wide policies. There was an emerging culture of implementing quality improvement audit tools to monitor and evaluate standards of care. There was an audit cycle in place and, therefore, the benefits of re-auditing were captured and audit results were monitored by the Audit Committee. The Audit Committee fed into the North Lee Mental Health Services Quality and Safety Committee.

The approved centre’s registered proprietor held overall responsibility for the risk management process. The St. Michael’s Unit risk register was monitored and maintained by the Incident Review Group which reportedly met every three months. Minutes for the Incident Review Group were not provided to the inspection team. Members of the Incident Review Group consist of the Assistant Director of Nursing (ADON), Clinical Nurse Manager III and the Clinical Director. This group did not appear to facilitate a direct multi-
disciplinary team approach in managing the approved centre’s risk register. Other disciplines emailed the group if they had anything to contribute to the risk register which did not promote multi-disciplinary discussion and decision making. Information in relation to the St. Michael’s Unit risk register reportedly fed into the North Lee Mental Health Services Management Team and the Quality and Safety Committee when appropriate, although it was not clear under what remit it was discussed by these Committees. The approved centre’s risk register fed into the wider risk register maintained by the Cork Mental Health Services Management Team. Incidents, trends, and complaints were reportedly discussed at the Incident Review Group. North Lee serious incidents, trends, and analysis were also discussed by the North Lee Quality and Safety Committee. The most prominent risks identified by the service were in relation to staff training, the premises, and residents’ unauthorised smoking on the unit. These risks were documented on the risk register; however, it was notable that there had been limited effective reduction and improvement with these risks.

The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE’s ‘Comment, Compliment or Complaint’ process and community meetings situated in the approved centre.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 15: Individual care plan</td>
<td>X High</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X High</td>
<td>X High</td>
<td>X Critical</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X Critical</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines</td>
<td>✓ High</td>
<td>X High</td>
<td>X Low</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Codes of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>✓ Low</td>
<td>X</td>
<td>X Moderate</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<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>
<tr>
<td>Regulation 13: Searches</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre 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>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 the approved centre did not use mechanical means of bodily restraint, 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 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.

During the inspection the inspection team spoke individually with two residents. Overall they were very complimentary about the care, the food, staff and the activities. Resident’s reported that they found not being able to go outside restrictive and un-therapeutic. Resident’s stated they would like the table tennis equipment to be more readily accessible.

In total one completed resident questionnaire was returned to the inspection team. The response contained in the questionnaire was mostly positive.

The Irish Advocacy Network feedback was complimentary regarding staff, the food and ward activities. Residents reported that they would like more arrangements for individual therapies and for access to the gym to be less cumbersome. Residents and family members commented that the experience of entering and exiting the unit felt somewhat custodial, this was largely due to the fact that a security guard was positioned at the main entrance and controlled access. Residents expressed their dissatisfaction at the conservatory being locked due to a minority of resident’s unauthorised smoking within the room. Residents who smoked and did not have leave off the unit felt that not being permitted to smoking within the unit or to go outside to smoke made their experience of being in the approved centre more difficult.

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:

- Area Director of Nursing
- Principal Clinical Psychologist
- Clinical Director of North Lee Mental Health Services
- Occupational Therapy Manager
- Area Administrator
- Clinical Nurse Manager III
- ADON
- Acting Clinical Nurse Manager II x3
- Therapy Clinical Nurse Manager II
- Head of Mental Health Cork and Kerry
- Social Work Team Leader
- Clinical Nurse Manager II
- Pharmacist

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

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

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

Evidence of Implementation: There were a minimum of two resident identifiers appropriate to the resident group profile and individual resident needs. Identifiers were person specific and were appropriate to the residents’ communication abilities. Identifiers included name, date of birth, medical record number and an identifying wristband. Two appropriate resident identifiers were used prior to administering medication, undertaking medical investigations and providing other healthcare services. Appropriate identifiers and alerts were in place to assist staff in ensuring the correct identification of resident who had the same or similar names.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in February 2019. The policy included all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre menus were approved by a dietician to ensure nutritional adequacy in accordance with residents’ needs. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of flavour, texture and appearance in order to maintain appetite and nutrition. Residents were provided with a variety of wholesome and nutritious food including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. Hot and cold drinks were offered to residents on a regular basis. A source of safe drinking water was available to residents at all times in easily accessible locations within the approved centre. Hot meals were provided on a daily basis.

No evidence-based nutrition assessment was used within the approved centre. Weight charts were implemented, monitored and acted upon for residents where appropriate. Nutritional and dietary needs were assessed and addressed in residents’ individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietician. Intake and output charts were maintained for residents where appropriate.

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

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

(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 January 2018. The policy included all requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** Appropriate hand-washing areas were provided for catering services and protective equipment including Personal Protective Equipment was used where required. There were proper facilities for the refrigeration, storage, preparation, cooking and service of food as well as suitable and sufficient catering equipment. Hygiene was maintained to support food safety requirements and catering areas and associated catering food safety equipment were appropriately cleaned. Food was prepared in a manner that reduced the risk of contamination, spoilage and infection. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs, including weighted cutlery and special cups which were available for people affected by coordination or swallowing issues.

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

The registered proprietor shall ensure that:

1. when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
2. night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in February 2018. The policy included all 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. A record of residents wearing nightclothes during the day was maintained and monitored.

**Evidence of Implementation:** Residents were supported to keep and use their personal clothing. Resident clothing was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity and bodily integrity as well as religious and cultural practices. Residents changed out of their nightclothes during the daytime unless specified otherwise in their individual care plans. Residents each had an adequate supply of individualised clothing.

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.

**Quality Rating**

COMPLIANT

Excellent
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 dated October 2018. The policy included all 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: Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property and possessions as necessary. Residents were entitled to bring personal possessions with them or her, the extent of which was agreed at admission.

Access to and use of resident monies was overseen by two members of staff and the resident themselves. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possession. The checklist was updated on an ongoing basis in line with approved centre policy. The property checklist was kept separately to the resident’s individual care plan.

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 February 2018. The policy included all 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: Recreational activities programmes were developed, implemented and maintained for residents with resident involvement. Recreational activities were available on weekends and weekdays and included darts, air hockey, table tennis, board games, gym equipment, books, and DVDs. Individual risk assessments were completed for residents as deemed appropriate.

A resident’s decision on whether or not to participate in activities was respected and documented as appropriate. The recreational activities provided by the approved centre were appropriately resourced. Opportunities were provided for indoor and outdoor exercise and physical activity: walks and visits to the coffee shop were arranged daily. Communal areas were provided that were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records.

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 February. The policy included all 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 was facilitated with the approved centre insofar as was practicable and there were facilities provided within the approved centre for resident’s religious practices. Residents had access to multi-faith chaplains and were supported to attend local religious services if deemed appropriate following risk assessment. Mass was celebrated in the church of the main hospital on a weekly basis. A Minister of the Eucharist attended the approved centre on a daily basis. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values. Any specific religious requirement relating to the provision of services, care and treatment were clearly documented. Each resident was facilitated to observe or abstain from religious practice in accordance with his or 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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in February 2018. The policy and procedures included all 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: At the time of the inspection there were no residents with restrictions on their visitors. A separate visitors’ room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied by an adult at all times to ensure their safety and this was communicated to all relevant individuals publicly. The visiting room 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 and procedures in relation to resident communication. The policy was last reviewed in February 2018. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed 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, internet and telephones. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and documented in the individual care plan. No residents had their communications monitored at the time of inspection.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in February 2018. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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

Evidence of Implementation: The file of one resident who had been searched was examined. Risk was assessed prior to the search of this resident and resident consent was sought prior to all searches. The request for consent and the received consent was documented as required. Where consent to a search was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents. During a search, a resident was informed by those implementing the search of what was happening and why.
minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to a resident’s dignity, privacy and gender.

A written record of every search of a resident and every property search was available which included the reason for the search, the names of both staff members who undertook the search and the details of those who were in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search. A written record of all environmental searches was maintained. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents.

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

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

(2) The registered proprietor shall ensure that when a resident is dying:

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

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

   (a) in so far as practicable, his or her religious and cultural practices are respected;
   
   (b) the resident’s death is handled with dignity and propriety, and;
   
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in February 2018. The policy and protocols included all 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: There had been no sudden or unexpected deaths in the approved centre since the last inspection. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: One clinical file of a resident who had died following discharge was examined. The death was notified to the Mental Health Commission no later than 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 addressed requirements of the Judgement Support Framework, with the exception of the time frames for assessment planning, implementation and evaluation of the ICP.

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

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

Evidence of Implementation: In total, ten ICPs were reviewed on inspection. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address immediate needs of the resident. All ICPs were stored within the clinical file, were identifiable and uninterrupted, and included allocated space for goals, treatment, care, resources required, and reviews. ICPs were not amalgamated with progress notes. One of the ICPs examined had not been reviewed and developed by the MDT following a comprehensive assessment, within seven days of admission.

In all ten ICPs reviewed, the comprehensive assessment included medical, psychiatric, and psychosocial history, as well as medication history, current medication, current physical health assessment, detailed risk assessment, and social, interpersonal, and physical environment related issues, including resilience and strength. The comprehensive assessments also included the residents’ communication abilities and educational, occupational, and vocational history. Evidence-based assessments were used where possible.

Residents’ ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. All ICPs identified the residents’ assessed needs, however two ICPs reviewed did not identify the appropriate goals for the resident. ICPs identified the care, treatment and resources required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. In addition, a key worker was identified to ensure continuity in the implementation of a residents’ ICP. All ten ICPs included an individual risk management plan. One ICP did not include a preliminary discharge plan.
Not all ICPs were reviewed by the MDT. ICPs were updated following review. Residents had access to their ICPs and were kept informed of any changes as well as being offered copies of their ICPs, including any reviews. This was documented. When a resident declined or refused a copy of their ICP, this was recorded, including the reason, if given.

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

a) One ICP was not developed by the MDT following a comprehensive assessment, within seven days of admission.

b) One ICP was not reviewed by the MDT.

c) One of the ICPs reviewed did not identify appropriate goals for the resident.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in February 2019. The policy included all 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 therapeutic activities and programmes, as set out in the policy.

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. Residents could provide feedback on therapeutic services and programmes and make suggestions through suggestion boxes and through focus groups that were held every four months. The therapeutic services and programmes provided by the approved centre were evidence-based and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of all therapeutic services and programmes provided in the approved centre was available to the residents. The therapy department facilitated multiple rolling groups. Groups run on a rolling basis included relaxation, mindfulness and peer support groups. Art therapy was delivered by an art therapist twice weekly. Other groups in the weekly schedule included, but were not limited to: problem solving group; social group, which is led by an occupational therapist; working towards discharge group; anxiety management group; a healing with compassion group; cooking group, craft group, and; an exercise group.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. Therapeutic services and programmes were provided in separate dedicated rooms containing facilities and space for individual and group therapies. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes in residents’ individual care plans or clinical files.

The 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 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 March 2018. The policy included all 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 been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: One clinical file relating to an emergency transfer of a resident was examined during the inspection process. Justification as to why consent of the resident was not received was appropriately documented. An assessment of the resident was completed prior to the transfer, including an individual risk assessment relating to the transfer and the resident’s needs. This was documented and provided to the facility. Full and complete written information for the resident was transferred to a named individual within the receiving facility. Information accompanied the resident upon transfer, to a named individual.

A letter of referral, including a list of current medications and a transfer form was issued as part of the transfer documentation. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility and copies of all records relevant to the resident transfer were retained in the resident’s clinical file.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which were dated February 2018. The policies and procedures addressed requirements of the Judgement Support Framework, with the exception of the resource requirements for general health services, including equipment needs.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the 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 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 have access at all times to an AED, and both were checked on a weekly basis. Records were available of any medical emergency within the approved centre and the care provided. Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with their individual care plans (ICPs).

Not all residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, but not less than every six months. Five clinical files were inspected for residents who had been in the approved centre for more than six months. One of the clinical files indicated that a general health assessment had not been completed within the required six months.

The six-monthly general health assessments that had been carried out documented: a physical examination; family and personal history; Body Mass Index, weight, and waist circumference; blood pressure, smoking status; nutritional status; medication review, and; dental health. For residents on anti-psychotic medication there was an annual assessment of their glucose regulation, blood lipids, prolactin, and an electrocardiogram.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. Residents had access to
national screening programmes that were available according to age and gender, including bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre and residents had access to smoking cessation programmes.

The approved centre was non-compliant with this regulation because not all residents residing in the approved centre for more than six months had received a general health check, 19(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 and procedures in relation to the provision of information to residents. The policy was dated February 2018. The policy and procedures included all 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 policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

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

Evidence of Implementation: Required information was provided to residents and their representatives at admission including the approved centre’s information booklet that detailed care and services. The booklet was available in the required format to support resident needs and contained: housekeeping arrangements, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies and details of resident rights. Residents were provided with details of their multi-disciplinary teams. Residents were provided with written and verbal information on diagnosis, unless, in the treating psychiatrist’s view, provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition.

Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side-effects. Medication information sheets as well as verbal information was provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for the use of all medications to be administered to the resident including any potential side-effects. The information provided by the approved centre was evidence based. Information documents provided by or within the approved centre are appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.
Regulation 21: Privacy

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

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<thead>
<tr>
<th>INSPECTION FINDINGS</th>
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<tr>
<td><strong>Processes:</strong> The approved centre had a written policy in relation to resident privacy, which was last reviewed in February 2018. The policy included all requirements of the <em>Judgement Support Framework</em>.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> 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.</td>
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<tr>
<td><strong>Monitoring:</strong> 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.</td>
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<td><strong>Evidence of Implementation:</strong> Residents were called by their preferred name and the general demeanour of staff promoted privacy and dignity of residents. Staff displayed discretion when discussing the residents’ condition or treatment needs and sought permission before entering their rooms as appropriate. At the time of the inspection, all residents were wearing clothes that respected their privacy and dignity. All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door which had override functions. The two-bedded rooms were small and did not ensure and safeguard resident privacy and dignity. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or any other identifiable information. Residents were facilitated to make private phone calls.</td>
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**The approved centre was non-compliant with this regulation because the 2-bedded rooms were not of an adequate size so as to ensure resident privacy and dignity.**
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in February 2018. The policy included all requirements of the Judgement Support Framework.

Training and Education: Relevant staff had not signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could not 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 not been completed to identify opportunities for improving the premises.

Evidence of Implementation: Not all residents had access to personal space within their bedrooms. There was no quiet space available to residents within the approved centre. The sitting room in the sub-acute area acted as a thoroughfare to the recreational room and was observed to be noisy at times. Appropriately sized communal rooms were not provided as the sitting room in the sub-acute unit was too small for the number of residents in the unit. There was no sitting room in the acute unit of the approved centre; instead, a lounge area with seating was situated in front of the nurse’s station.

There was suitable and sufficient central heating, with pipe work and radiators guarded, though the heating could not be controlled in the residents’ rooms in compliance with health and safety guidance and building regulations. Rooms were ventilated and private and communal areas were suitably sized and furnished to remove excessive noise. The lighting in communal rooms suited the needs of residents and staff; it was sufficiently bright and positioned to facilitate reading and other activities. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. However, ligature points were not minimised to the lowest practicable level. There were a number of ligatures that had not been addressed, including lights at beds,
windows, handrails, and pipes above ceiling tiles. Sufficient spaces were not provided for residents to move about as there was no outdoor space. Appropriate signage and sensory aids were not provided to support resident orientation needs.

The approved centre was not kept in a good state of repair internally or externally and there was no programme of general or decorative maintenance. Mould was observed on the ceiling and floors of showers and there was chipped paint on many doors. Some improvements were evident regarding general maintenance, however there was no maintenance plan. A number of ceiling tiles were missing and floors were badly stained and engrained with dirt. Some maintenance had commenced by the time of inspection and all ceiling vents had been cleaned.

There was a cleaning schedule implemented within the approved centre, though it was not free from offensive odours, as a smell of cigarette smoke was observed during each day of the inspection. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process and current national infection control guidelines were followed. Back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre and toilets were accessible, clearly marked, and were close to day and dining areas. Wheelchair accessible toilet facilities were identified for use by visitors who required such facilities and there was at least one assisted toilet per floor. The approved centre had a designated sluice room, cleaning room, and laundry room.

There was a designated therapy and examination rooms in the approved centre, as appropriate. Not all resident’s bedrooms were appropriately sized to address the residents’ needs and suitable furnishings were not provided to support resident comfort and independence. Where substantial changes were required to the approved centre’s premises, this was appropriately assessed prior to implementation for possible impact on current residents and staff and the Mental health Commission was informed prior to the commencement of works. Assisted devices and equipment were provided to address residents’ needs and remote or isolated areas of the approved centre were monitored.

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

a) The premises was not maintained in good structural or decorative condition, 22(1)(a).
b) The approved centre was not free of offensive odours, 22(1)(a).
c) A programme of routine maintenance and renewal of fabric and decoration of the premises was not developed or implemented and records of such a programme were not maintained, 22(1)(c).
d) The physical structure of the approved centre was not developed and maintained having due regard for the number and mix of residents in the approved centre, 22(3).
e) Ligature points had not been minimised, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. 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: Ten MPARs were reviewed on inspection. An MPAR was maintained for each resident, which detailed two appropriate resident identifiers, a record of any allergies or sensitivities to any medications, including if the resident had no allergies, as well as the names of medications and preparations written in full. In two MPARs reviewed, the generic name of the medication and preparation was not detailed. All MPARs had dedicated space for routine, once-off, and “as required (PRN) medications. The frequency of administration, including the minimum dose interval for PRN medication and the dose to be given was detailed in all MPARs; however, two MPARs did not contain micrograms written in full.

All MPARs examined included details of the administration route for medication, as well as a clear record of all medication administered to and refused by the resident. The date of initiation for each medication was clearly recorded in the MPARs, however there was no clear date of discontinuation for each medication in one MPAR. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was included in all MPARs, as was the signature of the medical practitioner or nurse prescriber for each entry.

All entries in the MPARs were legible and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident’s care or condition. This was documented in the clinical file. A prescription was not altered where changes were required. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription.
All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner. All medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident’s pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration and expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications.

When a resident’s medication was withheld, the justification was noted in the MPAR and documented in the clinical file. Where a resident refused the medication, this was also documented in the MPAR and clinical file and communicated to medical staff. Schedule 2 controlled drugs were checked by two staff members, one of which was a registered nurse, against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book and, following administration, the details were entered in the controlled drug book and signed by both staff members.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were clean and free from damp, mould, litter, dust, pests, as well as spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules and food and drink was not stored in areas used for the storage of medication. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as a refrigerator. Both medication trolleys in the approved centre remained locked at all times and were secured in a locked room.

Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. A system of stock rotation was implemented, to avoid accumulation of old stock, and an inventory of medications was conducted on a monthly basis, checking the name and dose of medication, the quantity of medication, and its expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was non-compliant with this regulation because a clear record of the date of discontinuation for each medication was not recorded in residents’ MPARs.
**Regulation 24: Health and Safety**

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The policy was dated March 2017. The policy addressed requirements of the *Judgement Support Framework,* with the following exceptions:

- Safety representative roles are allocated and documented.
- Infection control measures, including:
  - Raising awareness of residents and their visitors to infection control measures.
  - Availability of staff vaccinations and immunisations.
  - Support provided to staff following exposure to infectious diseases.
  - The monitoring and continuous improvement requirements implemented for the health and safety processes.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy and procedures did not address the following:

- The job description requirements.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.
Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. A planned and actual staff rota, showing the staff on duty at any one time during the day and night was maintained in the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs. All staff, including permanent, contract, and volunteers, were recruited, selected and vetted in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment. Staff had appropriate qualifications to do their job and information from referees was sought and documented. An appropriately qualified staff member was on duty and in charge at all times; this was documented. There was no written staffing plan for the approved centre.

There was the required number of staff on duty at night to ensure safety of residents. Where agency staff were used, there was a comprehensive contract between the approved centre and the registered staffing agency used that set out the agency’s responsibilities in relation to: the vetting of staff, including Garda vetting and references and vetting from other jurisdictions as appropriate; confirmation of registration, identity, and staff training; professional indemnity, and; arrangements for responding to complaints or concerns.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile and both orientation and induction training was completed for staff. Not all health care professionals were documented as having been trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001, or Children First. Additionally, not all staff had been trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan.

Staff had been trained in manual handling, dementia care, end of life care, residents rights, and incident reporting, as well as infection control and prevention, including sharps, hand hygiene techniques, and use of PPE. Staff were also trained in care for residents with an intellectual disability, recovery centred approaches to mental health care and treatment, and the protection of children and vulnerable adults. Staff had not been trained in risk management, including individual, organisational, and care and treatment provision as appropriate to staff role. All training was documented and staff training logs were maintained.

Opportunities were made available to staff by the approved centre for further education and these were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained and competent individuals and facilities and equipment were available for staff in-service education and training.

The Mental Health Act 2001, the associated regulation and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (40)</td>
<td>36</td>
<td>90%</td>
<td>19</td>
<td>47.5%</td>
<td>40</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>Acute Unit</td>
<td>CNM II</td>
<td>1</td>
<td>1 (between both units)</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1.5 (between both units)</td>
<td></td>
</tr>
<tr>
<td>Sub-Acute Unit</td>
<td>CNM1</td>
<td>1</td>
<td>1 (between both units)</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1.2 (between both units)</td>
<td></td>
</tr>
</tbody>
</table>

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)*

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

a) Not all staff had up-to-date training in Basic Life Support, fire safety, Professional Management of Aggression and Violence, or Children First, 26(4).

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

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.
(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.
(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was dated February 2018. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

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

The policy and procedures did not address record review requirements.

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. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All resident records were secure, up to date, in good order and were constructed, maintained and used in accordance with national guidelines and legislatives requirements. All resident records were physically stored together. A record was initiated for every resident assessed or provided with care by the approved centre. Resident records were reflective of the resident’s current status and the care being provided. Resident records were maintained using an identifier that was unique to the resident. Resident records were developed and maintained in a logical sequence. Records were maintained in good order, without loose pages. Records were accessible to authorised staff only and residents’ access to their records was managed in accordance with the Data Protection Acts.
Only authorised staff made entries in the records, or specific section therein. Records were written legibly in black, indelible ink. Entries were factual, consistent, and accurate and did not contain jargon. Each entry included the date and the time was noted using the 24-hour clock. Each entry was followed by a signature. Two appropriate resident identifiers were recorded on all documentation. Records were appropriately secured throughout the approved centre from loss or destruction and tampering. Not all corrections to errors made in residents’ progress notes had been dated, timed and initialled. Documentation of food safety, health and safety and fire inspections was maintained in the approved centre. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes 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.
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

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

- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The standardised operating policy and procedure layout used by the approved centre.

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

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had 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 were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, including services users, as appropriate. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The operating policies and procedures of the approved centre were appropriately approved and communicated to all relevant staff. All operating policies and procedures required to be reviewed within three years were reviewed accordingly. Obsolete versions of operating policies and procedures are retained but removed from possible access by staff.

The format of policies and procedures was standardised and included the title of the policy and procedure, the document owner and approvers, as well as the scope of the policy and procedure and the total number of pages. The reference number and revision of the policy and procedure, the reviewers, and the scheduled review date were not included in the standard policy format. While the initial implementation date was documented, there was no revised implementation date following the review of the policy.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in February 2018. The policy and procedures included all the requirements of the Judgement Support Framework.

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

Monitoring: Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided private facilities to support the Mental Health Tribunal process. However, adequate resources were not provided as there was no dedicated tribunal room. Instead, the approved centre used the Green room mainly and the occupational therapy (OT) room occasionally for tribunals. The OT room had paint on the table, floor and sink. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

The approved centre was non-compliant with this regulation because adequate Mental Health Tribunal resources were not provided. Tribunals were held in the OT kitchen where the table, sink, and floor were badly stained with paint which was not conducive to respecting resident’s dignity, 30(1).
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in February 2018. The policy and procedures addressed all requirements the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: 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 who was available to the approved centre and a consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make verbal, written, and telephone complaints, as well as through email and complaint, feedback or suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

Residents and their representatives were provided with information on the complaints procedure at admission or soon thereafter and the complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made and all complaints whether oral or written, were
investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being made.

A method for addressing minor complaints within the approved centre was provided and all minor complaints were documented. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations, were kept distinct from residents’ ICPs, though the outcomes were not recorded.

Timeframes were provided for responding to the complainant following the initial receipt of the complaint, the investigation period for complaints, and the required resolution of complaints. Where timeframes were not achieved or further investigation time was required in relation to the complaint, this was communicated to complainants. Complainants were informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them, and this was documented. Complainants’ satisfaction, or dissatisfaction, with the investigation findings were not documented.

Where services, care, or treatment was provided on behalf of the approved centre by an external party, the nominated person was responsible for the full implementation of the approved centre’s complaints management process, including the investigation process and communication requirements with the complainant. 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 relevant Data Protection Acts.

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 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in February 2018. The policy addressed requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- The responsibilities of the registered proprietor.
- The process of identification, assessment, treatment, reporting, and monitoring of organisational risks.
- The process of identification, assessment, treatment, reporting, and monitoring of risks to the resident group during the provision of general care and services.
- The process of identification, assessment, treatment, reporting, and monitoring of risks to individual residents during the delivery of individualised care.
- The process for responding to emergencies.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk
management processes. Management were not trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. Not 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 elements of the approved centre’s risk management policy. The audit did not measure actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Both clinical risks and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register, in accordance with relevant legislation.

The services Risk Management Procedures policy stated the Quality and Safety Committee “formulated” and “reviewed the risk register as part of the management of risk”. It also stated the risk register was to be “reviewed at each Quality and Safety Committee meeting”. In practice the risk register was updated and reviewed by the Incident Review Group. The Incident Review Group comprised medical and nursing staff and had no direct input from other multi-disciplinary team members. Communication with heads of discipline in relation to risk management within their areas of responsibility took place via email. Information in relation to the St. Michael’s Unit risk register reportedly fed into the North Lee Mental Health Services Management Team and the North Lee Quality and Safety Committee, although it was not clear in what capacity it was discussed. Senior management reported during inspection that the risk register was due to be formulated and reviewed by the North Lee Mental Health Services Senior Management Team in the future.

Structural risks, including ligature points, were not removed; however, they were effectively mitigated. Ligature works were on-going. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing. Corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register by the approved centre.

Individual risk assessments were completed prior to and during physical restraint, resident transfer and discharge, in conjunction with medication requirements or administration, and at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were also involved in the individual risk management process. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission and all information provided was anonymous at resident level. While there was a medical emergencies policy in the approved centre, responses by staff to other emergencies was not clearly outlined. The emergency plan did not incorporate evacuation procedures.

The approved centre was non-compliant with this regulation for the following reasons:
a) The registered proprietor did not ensure the risk management policy included all the required elements for the identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre as outlined above under processes, 32(2)(a).

b) The registered proprietor did not ensure the risk management policy included arrangements for responding to medical emergencies, 32(2)(e).

c) The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre as the risk register was updated and reviewed by the Incident Review Group and not the Quality and Safety Committee as per the services policy, 32(1).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration in relation to Regulation 21: Privacy and Regulation: 22 Premises attached. The certificate was displayed prominently on the approved centre’s main corridor.

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 that were not applicable on this inspection* for details.
10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2018. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.

It did not address the child protection process where a child is physically restrained.

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

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

Evidence of Implementation: Three episodes of physical restraint were examined during the inspection process. Physical restraint was used in rare, exceptional circumstances and in the best interest of the resident, where the resident posed an immediate threat of serious harm to themselves or others. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

In each case the physical restraint was used only after all alternative interventions to manage the residents’ unsafe behaviour had been considered. Physical restraint was initiated by a registered medical practitioner or registered nurse and a designated staff member was responsible for leading each episode. The Consultant Psychiatrist on duty was notified about the physical restraint as soon as was practicable. The registered medical practitioner completed a medical examination of the resident in all cases no later than three hours after the start of physical restraint and the order for the physical restraint lasted for a maximum of 30 minutes. Each episode of physical restraint was recorded in the resident’s clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered each use of physical restraint no later than three hours after the episode, which was subsequently signed by the consultant psychiatrist within 24 hours.

In all three cases reviewed the resident was informed of the reasons for, likely duration of and circumstances leading to the discontinuation of physical restraint. As soon as was practicable and with the resident’s consent, the resident’s next of kin or representative was informed of the use of physical restraint, with a record of communication placed in the clinical file. Where, as in one case, the resident had capacity and did not consent to informing their next of kin or representative, this was documented in the resident’s clinical file. Staff were aware of relevant considerations in individual care plans pertaining to the residents’ requirements in relation to the use of physical restraint.

Where practicable, same sex staff members were present at all times during the episodes of physical restraint. In all three cases the resident was afforded an opportunity to discuss the episode of physical restraint with members of the multi-disciplinary team involved in the restraint. All three completed CPFs
were placed in their respective clinical files. Each episode of physical restraint was reviewed by members of the multi-disciplinary team within two working days and this was documented within the clinical file.

The approved centre was non-compliant with this code of practice because the policy on physical restraint did not include child protection processes where a child is physically restrained, 11.2.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was dated February 2018, included all policy-related criteria for this code of practice.

Transfer: The transfer policy, which was dated March 2019, included all policy-related criteria for this code of practice.

Discharge: The discharge policy, which was dated February 2018, included all policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: A key worker system was in place within the approved centre. Documentation relating to the admission of one resident was examined during the inspection process. The admission was on the basis of a mental illness or disorder and an admission assessment was completed, which included: the presenting problem; past psychiatric, family, and medical history; current and historic medication; current mental health state; risk assessment; a full physical examination, and; any other relevant information, such as work situation, education, or dietary requirements. The resident’s family member, carer, or advocate was involved in the admission process, with the resident’s consent.

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

Discharge: One clinical file of a resident who had been discharged was inspected. The discharge plan included an estimated date of discharge, a follow-up plan, a reference to early warning signs of relapse and risks, and documented communication with the relevant general practitioner, primary care team, or community mental health team. The discharge meeting was attended by the resident, key worker, relevant members of their multi-disciplinary team, and family, carer, or advocate, where appropriate.

Discharge assessments addressed the resident’s psychiatric, psychological, and informational needs, as well as a current mental state examination and a comprehensive risk assessment and risk management plan. The discharge was coordinated by a key worker and a preliminary discharge summary was sent to the general practitioner, primary care team, or community mental health team, as appropriate, within three days of discharge.
A comprehensive discharge summary was issued within 14 days and included the resident’s diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues, such as signs of relapse.

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

### Regulation 15: Individual Care Plan

**Reason ID: 10000784**

One ICP was not developed by the MDT following a comprehensive assessment, within seven days of admission. One ICP was not reviewed by the MDT. One of the ICPs reviewed did not identify appropriate goals for the resident.

<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>An ICP MDT group was set up to review the ICPs and made following actions. Psychology Dept will facilitate 2 goal setting workshops for all staff. (1 each end of week, 1 in 1st quarter and 1 in 2nd Quarter). ICP leads will be identified in each team. Their role will be to ensure each ICP is filled out correctly and reviewed etc.</td>
<td>Attendance at goal setting workshop will be noted. ICP audits will be sent directly to ICP leads so we can address any issues arising efficiently.</td>
<td>Achievable</td>
<td>31/05/2020</td>
<td>Heads of Discipline</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>ICP audits to be completed regularly and results disseminated to all staff</td>
<td>Audit</td>
<td>Achievable</td>
<td>31/05/2020</td>
<td>Heads of Discipline</td>
</tr>
</tbody>
</table>
Regulation 19: General Health

<table>
<thead>
<tr>
<th>Reason ID : 10000772</th>
<th>Not all residents residing in the approved centre for more than six months had received a general health check, 19(b).</th>
</tr>
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</table>

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<tr>
<th></th>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>CD has spoken with relevant staff and email has been sent to all medical and nursing staff to ensure 6 monthly health checks are completed</td>
<td>Audit</td>
<td>Achievable</td>
<td>30/04/2020</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>6 Monthly physical book in place. Reminder placed in ward diary to check patients' admission dates on the 1st Sunday of every month and follow up on same. Nursing Staff to report any difficulties with completion of 6 monthly physicals to Consultant/Clinical Director all that are due.</td>
<td>Audit</td>
<td>Achievable</td>
<td>30/04/2020</td>
<td>Consultants, NCHDs, CNM2s</td>
</tr>
</tbody>
</table>
### Regulation 21: Privacy

**Reason ID: 10000787**

The 2-bedded rooms were not of an adequate size so as to ensure resident privacy and dignity.

<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>Room F1.49 was refurbished into a single room allowing reduction in room F1.37 from 2 beds to 1. The remaining room containing 2 beds has structural survey completed and awaiting results from engineering dept. to allow breaking through to adjoining office space to create sufficiently large space.</td>
<td>Works completed in F1.49 and F1.37 reduced to single room</td>
<td>Achievable</td>
<td>31/05/2020</td>
<td>Area Administrator</td>
<td></td>
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</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>Room F1.37 and F1.49 will be single occupancy spaces while room F1.36 will be sufficiently large enough to accommodate 2 bed spaces and is served with en-suite</td>
<td>Spaces will be sufficiently large enough to accommodate patients dignity and privacy.</td>
<td>It is anticipated that works will be completed in Quarter 2</td>
<td>31/05/2020</td>
<td>Area Administrator</td>
<td></td>
</tr>
</tbody>
</table>
Regulation 22: Premises

### Reason ID: 10000779

The physical structure of the approved centre was not developed and maintained having due regard for the number and mix of residents in the approved centre, 22(3).

<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>Re-organisation of congested work spaces was completed, Files removed to appropriate storage, fire stop works and emergency exits door releases undertaken. Room F1.49 refurbished to single room, shower area ventilation upgraded, badly marked ceiling tiles replaced in OT kitchen,</td>
<td>Subject to ongoing audits.</td>
<td>Achieved</td>
<td>31/10/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Phase 3 painting works booked in with contractor, replacement of ceiling tiles on main corridors with MUH technical services for specification for contractor pricing.</td>
<td>Audit</td>
<td>Achievable</td>
<td>30/04/2020</td>
</tr>
</tbody>
</table>

### Reason ID: 10000780

Ligature points had not been minimised, 22(3).

<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>Specification developed for replacement of</td>
<td>Audit and risk assessment</td>
<td>Achievable</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>St. Michaels unit is subject to ongoing audit and risk assessment to review the anti ligature status of the unit.</td>
<td>Audit and risk assessment results are discussed at both QPSD and local management team meetings.</td>
<td>Achievable</td>
<td>31/03/2020</td>
</tr>
</tbody>
</table>
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

<table>
<thead>
<tr>
<th>Reason ID: 10000781</th>
<th>A clear record of the date of discontinuation for each medication was not recorded in residents' MPARs.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Email sent by Clinical Director on 9/09/2019 to All medical staff highlighting importance of discontinuation dates</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3 monthly audits</td>
<td>Achievable</td>
<td>30/04/2020</td>
<td>Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>

| Preventative Action | Audit completed and feedback provided to medical staff. Will continue 3 monthly audits                    | Achievable | 30/04/2020          | Clinical Director |
Regulation 26: Staffing

Reason ID: 10000782

<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>Communication sent by all HOD re maximising the training that is accessible online. PMAV training dates have been made available. Emails sent to staff via their line managers re communicating same and booking next available dates in. New dates for BLS have been circulated also, all line managers encouraging staff to attend and prioritise this training</td>
<td>All HOD to update shared folder for training logs</td>
<td>Achievable</td>
<td>30/04/2020</td>
<td>Heads of Discipline</td>
<td></td>
</tr>
</tbody>
</table>

Preventative Action

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colour coded excel sheet available to HOD to support notifying staff in a timely manner when training is due to expire. All staff to complete mandatory training before</td>
<td>Audits will be carried out and circulated to the HODs for follow up</td>
<td>Achievable</td>
<td>30/04/2020</td>
<td>Heads of Discipline</td>
<td></td>
</tr>
<tr>
<td>Application for CPD activities are considered for approval. Staff training to be reviewed at HOD meeting regularly.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
### Regulation 30: Mental Health Tribunals

**Reason ID: 10000770**

Adequate Mental Health Tribunal resources were not provided. Tribunals were held in the OT kitchen where the table, sink, and floor were badly stained with paint which was not conducive to respecting resident's dignity, 30(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Health Tribunals are now held in the Green Room</td>
<td>Audit</td>
<td>Completed</td>
<td>31/01/2020</td>
<td>Area Administrator, Nurse Therapy</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>Consideration to be given to inclusion of specific meeting / tribunal space in line with capital configuration</td>
<td>Audit</td>
<td>Realistic</td>
<td>30/04/2020</td>
<td>Area Administrator</td>
</tr>
</tbody>
</table>
### Regulation 32: Risk Management Procedures

**Reason ID: 10000773**  
The registered proprietor did not ensure the risk management policy included all the required elements for the identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre as outlined above under processes, 32(2)(a).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Policy amended, reviewed and implemented to include all required elements.</td>
<td>Audit on Regulation 32.</td>
<td>Achieved</td>
<td>01/01/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Nursing Staff to report any difficulties with completion of 6 monthly physicals to Consultant/Clinical Director Review Policies regularly to ensure all elements of the JSF are included.</td>
<td>Ongoing audits</td>
<td>Achievable</td>
<td>31/03/2020</td>
</tr>
</tbody>
</table>

**Reason ID: 10000774**  
The registered proprietor did not ensure the risk management policy included arrangements for responding to medical emergencies, 32(2)(e).

<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>Policy amended, reviewed and implemented to include arrangements for responding to medical emergencies.</td>
<td>Audit on Regulation 32</td>
<td>Achieved</td>
<td>01/01/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Review Policies regularly to ensure all elements of the JSF are included.</td>
<td>Audits</td>
<td>Achievable</td>
<td>30/04/2020</td>
</tr>
</tbody>
</table>
Reason ID: 10000775

The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre as the risk register was updated and reviewed by the Incident Review Group and not the Quality and Safety Committee as per the services policy, 32(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>Quality and Safety Committee to review risk register at next meeting in Feb 2020</td>
<td>Review Minutes</td>
<td>Achievable</td>
<td>29/02/2020</td>
<td>QPS Committee</td>
<td></td>
</tr>
</tbody>
</table>

| Preventative Action                    | Ensure risk register remains on HOD and QPS Agenda                       | Review Minutes | Achievable           | 29/02/2020 | QPS and HOD Committee |
Code of Practice on the Use of Physical Restraint in Approved Centres

Reason ID: 10000771  
The policy on physical restraint did not include child protection processes where a child is physically restrained, 11.2.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Restraint Policy amended to include child protection processes approved and implemented Sept 2019</td>
<td>Audit to be completed every 3 months</td>
<td>Completed</td>
<td>30/09/2019</td>
<td>Policy Committee</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Review Policies regularly to ensure that all elements of the JSF are included</td>
<td>Audits and discussion at bi monthly meetings</td>
<td>Achievable</td>
<td>29/02/2020</td>
<td>Policy Committee</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.