Grangemore Ward & St Aidan's Ward, St Otteran's Hospital

ID Number: AC0033

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Grangemore Ward & St Aidan's Ward, St Otteran's Hospital
John’s Hill
Waterford

Conditions Attached: None

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

Registered Proprietor: HSE

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

Most Recent Registration Date: 1 March 2017

Registered Proprietor Nominee:
Mr David Heffernan, General Manager, CHO5 Mental Health Services

Inspection Team:
Karen McCrohan, Lead Inspector
Mary Connellan
Noeleen Byrne
Siobhán Dinan

Inspection Date: 26 – 29 March 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 20 – 23 August 2018

Date of Publication: Tuesday 17 September 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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In brief

The approved centre consisted of two separate wards, Grangemore and St. Aidan’s. Both wards were located in separate parts of St. Otteran’s Hospital campus on the outskirts of Waterford city. Grangemore ward was a Rehabilitation and Recovery unit, which accommodated 16 residents at full capacity. St. Aidan’s ward was registered for 24 beds, which operated under the Psychiatry of Older Adult team. At the time of the inspection, a new build was in progress within St. Patrick’s Hospital which will accommodate the residents in St. Aidan’s ward who are under the care of the Psychiatry of Older Adult team.

There continues to be low compliance (68%) with regulations, rules and codes of practice. However, this is an improvement form 2017 when compliance was 50%. Seven non-compliances with regulations had been non-compliant for three years. Six non-compliances were rated high risk, and Regulation 16: Therapeutic Services and Programmes was rated critical risk. Compliance in one regulation, Regulation 7: Clothing, was rated excellent.

Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.
- Although quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines, the ordering, prescribing, storage and administration of medication was satisfactory.

However:

- Despite significant improvements in the area of mandatory training, not all staff had up-to-date training on Basic Life Support, fire safety, management of violence and aggression, the Mental Health Act 2001 and Children First.
• When a resident was transferred from the approved centre for treatment in another hospital, not all relevant information about the resident was provided to the receiving hospital, which could have resulted in the resident receiving inadequate or incorrect treatment.
• The number of staff was not sufficient to address the assessed needs of the residents. The nursing staff complement on Grangemore ward was noted to be one nurse short on three occasions within a four-week period.

Appropriate care and treatment of residents

• Residents were assessed at admission and an individual care plan (ICP) was drawn up by the multi-disciplinary team (MDT) within seven days, following a comprehensive assessment. The ICPs identified the residents’ assessed needs and the goals and resources required to provide the care and treatment specified. The ICPs were written annually and reviewed by the MDT six-monthly. They were reviewed by the key worker monthly.
• An evidence-based nutrition assessment tool was used. Where appropriate, weight charts were implemented, monitored and acted upon.
• Registered medical practitioners assessed residents’ physical health on admission, and general health needs were managed on an ongoing basis as part of the approved centre’s provision of care. At a minimum, a six-monthly general health assessment had been completed.

However:

• There was no therapeutic programme for residents in St Aidan’s ward apart from a weekly yoga session and dog therapy on Wednesdays. Individual MDT input was limited and no therapeutic programmes, including dementia appropriate therapies, were facilitated by the Psychiatry of Older Adult MDT despite this being the team responsible for care and treatment for the residents in St. Aidan’s ward.
• There was inadequate monitoring of physical health of residents.

Respect for residents’ privacy, dignity and autonomy

• Visiting times were publicly displayed and were appropriate and reasonable. There were no visiting restrictions for any of the residents. Both wards had appropriate visiting rooms or areas available where residents could meet visitors in private.
• All bathrooms, showers, toilets, and single bedrooms had locks with an override function on the inside of the door, unless there was an identified risk to a resident. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.
• The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
• The approved centre was compliant with the Code of Practice on the Use of Physical Restraint.

However:
• In St. Aidan’s ward, the residents’ privacy and dignity was not appropriately respected. The accommodation in St. Aidan’s ward consisted of two large dormitories and one single bedroom. The beds within the dormitories were located too close together, which limited residents’ access to personal space. The unoccupied space, within the dormitories, was used for storage. The dormitories were not gender specific.

• There was insufficient number of toilets for the residents in St. Aidan’s ward. At the time of the inspection, nine male residents shared one toilet. A second toilet was inaccessible.

• The approved centre was not clean, hygienic and free from offensive odours. The outdoor spaces in Grangemore ward were littered with cigarette butts. Not all of the rooms were adequately ventilated and toilets in both wards were malodorous.

• The approved centre was not kept in a good state of repair. Internal wall paint was peeling or chipped and floor coverings were damaged in both units. The ceilings were damaged in three areas due to leaks, a corridor in Grangemore ward and in the sitting room and toilet in St. Aidan’s ward. While there was evidence that maintenance issues had been previously reported, the issues had not been resolved.

• CCTV cameras which were used to observe a resident were capable of recording or storing a resident’s image, which is in breach of Regulation 25: Use of CCTV.

• Mechanical Restraint was used in the approved centre in the form of lap-belts. It was not used in accordance with the Rules governing its use:
  o Three out of five clinical files did not indicate that mechanical restraint was only used when less restrictive alternatives were deemed unsuitable.
  o Three clinical files did not record that less restrictive alternatives were implemented without success.
  o One clinical file did not specify the duration of the mechanical restraint.
  o Four clinical files did not specify a review date.

**Human Rights**

There was a breach of human rights of human rights evident in the approved centre at the time of inspection: Mechanical Restraint was used in the approved centre in the form of lap-belts. It was not used in accordance with the Rules Governing the Use of Seclusion and Mechanical Restraint.

**Responsiveness to residents’ needs**

• Residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals, including modified consistency diets.

• The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Recreational activities provided included TV and DVDs, books, puzzles, board games, pool, a walking group, gardening and a sports group. Residents had access to a pool table in Grangemore ward. There was a weekly music group in St. Aidan’s and residents listened to music daily. Residents from both wards were accompanied on day trips to local
amenities and the residents in Grangemore had a minibus for their use. All single bedrooms had a television.

- Written information was provided about the approved centre, residents’ diagnoses and medication.
- There was a robust complaints policy in place.

**Governance of the approved centre**

- The approved centre was part of South East Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 5, and was governed under the Waterford/Wexford Mental Health Services. Waterford/Wexford Mental Health Service’s governance processes encompassed two core monthly meetings, the Waterford/Wexford Executive Management Team Meeting and Quality and Safety Executive Committee meeting. Governance was strengthened by a local Quality and Patient Safety Committee meeting and a newly established Health and Safety Committee meeting, which addressed issues within Grangemore and St. Aidan’s ward.
- The approved centre’s policies were developed by the Policy Development Committee and were regularly reviewed.
- An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.
- The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns occurring in the service.

However:

- Only a limited number of audits were completed since the last inspection. However, at the time of the inspection, staff within the approved centre were in the process of developing an audit schedule.
- The number of staff within Grangemore and St. Aidan’s wards was insufficient to meet resident needs. This deficiency mainly pertained to the nursing discipline as the approved centre’s core nursing staff was augmented by 14 agency nurses. Not all staff had received mandatory training.
The following quality initiatives were identified on this inspection:

1. Development of a new multi-purpose room in the Grangemore Ward, which was used as a relaxation or visitors’ room.

2. Introduction of a new process in St. Aidan’s Ward for providing residents and their families with information.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre consisted of two separate wards, Grangemore and St. Aidan’s. Both wards were located within the St. Otteran’s Hospital campus on the outskirts of Waterford city. Staff within Grangemore ward also had oversight of two medium support residences, Sarto and Raheen. However, these two four-bedded residences did not form part of the approved centre.

Grangemore ward was a Rehabilitation and Recovery unit, which accommodated 16 residents at full capacity. St. Aidan’s ward was registered for 24 beds, which operated under the Psychiatry of Older Adult team. Both Grangemore and St. Aidan’s wards contained a communal sitting room, dining room, multi-purpose room and an enclosed garden. Residents’ access to the garden in St. Aidan’s ward was restricted as the door was locked due to the requirement for resident supervision. Residents in Grangemore ward also had access to a pool room. The accommodation in Grangemore ward consisted of two four-bedded dormitories, one two-bedded dormitory and six single bedrooms. At the time of the inspection, residents in St. Aidan’s ward were accommodated within two large mixed gender dormitories, with one resident accommodated within the sole single bedroom.

Neither unit was maintained in good structural or decorative condition as there was no routine programme of maintenance. At the time of the inspection, a new build was in progress within St. Patrick’s Hospital, which will accommodate the residents in St. Aidan’s ward who are under the care of the Psychiatry of Older Adult team.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>40</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>26</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>1</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>25</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was part of South East Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 5, and was governed under the Waterford/Wexford Mental Health Services. The approved centre’s registered proprietor nominee was the General Manager within the Waterford/Wexford Mental Health Service. Waterford/Wexford Mental Health Service’s governance
processes encompassed two core monthly meetings, the Waterford/Wexford Executive Management Team Meeting and Quality and Safety Executive Committee meeting. Governance was strengthened by a local Quality and Patient Safety Committee meeting and a newly established Health and Safety Committee meeting, which addressed issues within Grangemore and St. Aidan’s ward. Minutes were maintained for each meeting; each evidenced discussions on issues such as risk management, quality and patient safety, compliance, complaints/compliments, policies/procedures/protocols/guidelines, and performance monitoring.

The approved centre’s policies were developed by the Policy Development Committee. 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. All of the required operating policies and procedures were reviewed within a three-year period. Only a limited number of audits were completed since the last inspection. However, at the time of the inspection, staff within the approved centre were in the process of developing an audit schedule.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The number of staff, within Grangemore and St. Aidan’s wards, were insufficient to meet resident needs. This deficiency mainly pertained to the nursing discipline as the approved centre’s core nursing staff was augmented by 14 agency nurses. At the time of the inspection, there were 42 nursing posts vacant in County Waterford. Within the wider service, there was no principal social worker within the mental health service and due to the absence of a clinical director, the Executive Clinical Director was covering both medical roles. Despite significant improvements in the area of mandatory training, not all staff had up-to-date training on basic life support, fire safety, management of violence and aggression, the Mental Health Act 2001 and Children First.

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

The Mental Health Commission’s Governance Questionnaire was issued to the approved centre in advance of the inspection. Three completed questionnaires were returned; Area Director of Nursing, Occupational Therapy Manager, and Service Manager. These Heads of Discipline outlined regular engagement with staff and clear lines of responsibility. Staff shortages, lack clinical space, restricted access to mandatory training, lack of a Principal Social Worker and access to occupational therapists for seating assessments were identified as the main operational risks within the submitted questionnaires.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
<td>✔</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>X</td>
<td>Critical</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>X</td>
<td>High</td>
<td>✔</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Critical</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>✔</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>Low</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Low</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following area was rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</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>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>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.

The inspection team met with five residents and two family members during the inspection. Both the residents and their family members were complimentary of the care and treatment provided. The residents were aware of their multi-disciplinary team (MDT) and individual care plan (ICP). The food and the facilities provided were described positively by all of the residents.

Three residents completed the ‘Your Views’ Mental Health Commission questionnaire. On a scale of 1 -10, with 1 being poor and 10 being excellent, all of the residents rated their overall experience of care and treatment as 8 and above. The residents reported that they were provided with appropriate information, were involved in setting goals for their individual care plan (ICP), and described feeling safe. However, two of the three residents reported that they would like more activities within the ward.
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:

- General Manager - Registered Proprietor Nominee
- Hospital Manager
- Area Director of Nursing
- Assistant Director of Nursing (x2)
- Consultants (x2)
- Psychology Manager
- Occupational Therapist Manager
- Risk Manager
- Clinical Nurse Manager (x2)

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Any relevant information provided to the inspection team at the feedback meeting was included within the report.
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 April 2018. The policy 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 were able to articulate the processes for identifying residents, as set out in the policy.

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

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs, were used. The preferred identifiers were detailed within the residents’ clinical files. Identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing health care services and therapeutic services and programmes. There was an alert system for identifying residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in July 2018. The policy 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 were able to articulate the processes for food and nutrition, as set out in the policy.

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

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals, including modified consistency diets. Hot meals were provided on a daily basis. Meals were attractive and appealing in presentation. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times.

An evidence-based nutrition assessment tool was used. Where appropriate, weight charts were implemented, monitored and acted upon. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. The needs of residents identified as having special nutritional requirements were assessed and addressed in the residents’ individual care plans. These had not been regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating: Satisfactory
(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 March 2019. The policy 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 were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

**Monitoring:** Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

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

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
Regulation 7: Clothing

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in April 2018. The policy 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 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. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Residents were provided with appropriate emergency clothing when required. Residents changed out of nightclothes during the day and all residents 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.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in May 2018. The policy 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 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 not 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 safekeeping of monies, valuables, and personal effects. The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Residents also had access to individual lockers and presses.

The approved centre had compiled a detailed property checklist for each resident. These were filed separately from the resident’s individual care plan and were available to residents. Residents were supported to manage their own property, unless it posed a danger to the resident or others, as indicated in their individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in June 2018. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The process for developing recreational activity programmes.
- The facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to the approved centre.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Notices outlining the weekly schedule for recreational activities were displayed in both wards. Recreational activities provided included TV and DVD’s, books, puzzles and board games. Active recreational activities included a walking group and a sports group. Residents had access to a pool table in Grangemore ward. There was a gardening group for the residents in Grangemore ward. Residents in St. Aidan’s had limited access to the garden; the garden door was locked as the residents required supervision. There was a weekly music group in St. Aidan’s and residents listened to music daily. Residents from both wards were accompanied on day trips to local amenities and the residents in Grangemore had a mini bus for their use. All single bedrooms had a television.

The recreational activity programme had been developed, implemented and maintained for residents with resident involvement. Individual risk assessments had been completed in relation to the selection of appropriate activities. Resident decisions on whether to participate or not were respected and documented, as appropriate. The recreational activities were appropriately resourced and there were opportunities for indoor and outdoor exercise and physical activity. Documented records of attendance had been retained in group records in the nursing handover books and within the residents’ clinical files.

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

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

<table>
<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 the facilitation of religious practice by residents, which was last reviewed in May 2016. The policy included all the requirements of the <em>Judgement Support Framework</em>.</td>
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<tr>
<td><strong>Training and Education:</strong> 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.</td>
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<tr>
<td><strong>Monitoring:</strong> The implementation of the policy to support residents’ religious practices was not reviewed to ensure that it reflected the identified needs of residents.</td>
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<tr>
<td><strong>Evidence of Implementation:</strong> Residents were facilitated to practice their religion insofar as was practicable. A Eucharistic Minister visited the approved centre weekly. Residents had access to multi-faith chaplains.</td>
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The care and services provided in the approved centre were respectful of the residents’ religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
Regulation 11: Visits

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.

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

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

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.

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

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 September 2016. The policy and procedures addressed requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

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

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

Evidence of Implementation: Visiting times were publicly displayed and were appropriate and reasonable. There were no visiting restrictions for any of the residents. Both wards had appropriate visiting rooms or areas available where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting the approved centre were accompanied at all times to ensure their safety.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
Regulation 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 January 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 were able to articulate the processes for communication, as set out in the policy.

**Monitoring:** There were no restrictions on residents’ communication at the time of the inspection. Documented analysis had not been completed to identify ways of improving communication processes.

**Evidence of Implementation:** Residents had access to a range of communications, including telephone, e-mail and internet. 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. At the time of inspection, no resident had any risks associated with their external communication.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in May 2018. The policy and procedures addressed all 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.

As no search had been conducted in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not applicable.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in July 2018. The policy and protocols 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 were able to articulate the processes for end of life care, as set out in the policy.

Monitoring: End of life care provided to residents was not systematically reviewed to ensure section 2 of the regulation had been complied with. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The clinical file of one resident who had died in the approved centre was reviewed. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of the resident, who was nursed in a single room. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Pain management was prioritised and managed during end of life care.

Advanced care directive relating to end of life care, as well as a Do Not Attempt Resuscitation (DNAR) order was documented as applicable. Support was given to other residents and staff following a resident’s death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.
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 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 June 2018. The policy included all the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Ten ICPs were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs included an individual risk management plan and a preliminary discharge plan where applicable.

Residents were assessed at admission and an ICP was drawn up by the multi-disciplinary team within seven days, following a comprehensive assessment. The ICPs identified the residents’ assessed needs and the goals and resources required to provide the care and treatment specified. The ICPs were written annually and reviewed by the MDT six-monthly. They were reviewed by the key worker monthly.

As applicable, the ICP had been developed with resident involvement and a copy had been given or offered to the resident.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 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 June 2018. The policy included all the requirements of the Judgement Support Framework.

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

Monitoring: The range of services and programmes provided in the approved centre was 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 evidence-based. A list of all therapeutic services and programmes provided was available to the residents in Grangemore ward but not in St. Aidan’s ward. There had been a small improvement in the resources allocated to provide therapeutic services and programmes. A separate dedicated room, containing facilities and space for individual and group therapies, was not provided within the approved centre. The residents did have access to an occupational therapy kitchen and an Activation Therapy Unit (ATU) within the hospital campus. 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 therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents in Grangemore ward but not in St. Aidan’s ward. The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of the residents in St. Aidan’s ward. In Grangemore ward, the occupational therapist facilitated a weekly group session. Residents attended a Breakfast Club, which was held every Tuesday. Residents could attend baking sessions, which were facilitated by the occupational therapist, in the deconsecrated church on the campus. Residents also accessed the therapeutic programmes available within the ATU. Examples of groups included a sign language and walking group co-facilitated by the social worker, music therapy group, arts group and Kickstart to Recovery group. Residents had access to a social worker, psychologist and occupational therapist for individual input through the multi-disciplinary team.

In St. Aidan’s ward, seating assessments were completed by an external occupational therapist. A weekly yoga session was facilitated by an external facilitator and there was dog therapy on Wednesdays. Individual multi-disciplinary team input was limited. For example, the psychologist had assessed one resident for a behavioural support plan. No therapeutic programmes were facilitated by the Psychiatry...
of Older Adult multi-disciplinary team, for the residents in St. Aidan’s ward. Due to the resident group profile within St. Aidan’s ward, most of the residents were unable to attend the ATU independently.

At the time of the inspection, a new basic grade agency occupational therapist was being inducted to the service. Furthermore, the approved centre had obtained funding for the development of a sensory garden and a sensory room within St. Aidan’s ward.

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

a) The registered proprietor did not ensure that each resident in St. Aidan’s ward had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16(1).

b) The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).
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 May 2018. The policy 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 were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one transfer was reviewed during the inspection. Communication records with the receiving facility were not documented and available on inspection. There was no documentary evidence of verbal communication and liaison between the approved centre and the receiving facility prior to the transfer taking place. The consent of the resident to the transfer was not documented within the clinical file and there was no justification documented as to why consent was not received.

An assessment of the resident prior to transfer, including an individual risk assessment, was not evident within the resident’s clinical file. Full and complete written information was not transferred when the resident moved from the approved centre to the receiving facility; this included no transfer form. While a letter of referral was issued to the receiving facility, it did not outline the resident’s list of current medications. A checklist was not 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 not retained in the resident’s clinical file.

The approved centre was non-compliant with this regulation because when a resident was transferred from the approved centre for treatment in another hospital, the registered proprietor of the approved centre from which the resident was being transferred did not ensure that all relevant information about the resident was provided to the receiving hospital, 18(1).
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in May 2018. The policy and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The management, response and documentation of a medical emergency, including cardiac arrest.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to 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 not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: Staff had access to an Automated External Defibrillator (AED), which had been checked weekly. The approved centre did not have an emergency trolley. However, the approved centre had a process to manage medical emergencies. Records were available of any medical emergency that had occurred within the approved centre and the care implemented.

Registered medical practitioners assessed residents’ physical health on admission, and general health needs were managed on an ongoing basis as part of the approved centre’s provision of care. At a minimum, a six-monthly general health assessment had been completed. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. National screening information was available, and residents had access to national screening programmes as applicable.

The six monthly general health assessment for five residents were reviewed by the inspection team. The six monthly general health assessments documented the physical examination and the family and personal history as relevant. The Body Mass Index (BMI), weight and waist circumference was not...
recorded for three of the five assessments reviewed. Two assessments did not record the smoking status of the resident and one assessment did not record the nutritional status. An annual dental check had not been recorded for all five residents. The inspection team were informed that residents in Grangemore did attend a dentist when problems arose and a dentist was available to visit St. Aidan’s to do an assessment if required.

For residents on antipsychotic medication, there was evidence of an annual assessment of glucose regulation, fasting glucose and prolactin levels. Each resident, as applicable, had an electrocardiogram (ECG). There was no documentary evidence to indicate that an assessment of blood lipids had been completed for one resident.

The approved centre was non-compliant with this regulation because the six monthly physical assessments were incomplete. Not all of the assessments included smoking status, nutritional status, BMI, weight and waist circumference, dental assessment and an assessment of blood lipids, 19(1).
Regulation 20: Provision of Information to Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in May 2018. The policy and procedures included all the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: An information booklet specific to each ward was provided to residents and their representatives on admission. This contained details of the housekeeping arrangements such as mealtimes, the complaints procedure, visiting times and arrangements, the arrangements for personal property, and details of the relevant advocate and voluntary agencies. The booklet addressed residents’ rights. Residents and their families were provided with information on their multi-disciplinary team.

Residents and their families received written and verbal information regarding diagnosis and the likely adverse effects of treatment. Medication information sheets as well as verbal information were provided, and these included information on indications for use and possible side effects of medication. In St. Aidan’s ward the resident and their family were provided with individual pouches containing all the relevant information. The information provided by the approved centre was evidence-based and had been appropriately reviewed. If required, residents had access to interpretation and translation services.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2018. The policy addressed requirements of the Judgement Support Framework, except for the process for addressing a situation where resident privacy and dignity is not respected by staff.

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

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

Evidence of Implementation: Staff had an appropriate demeanour and dressed appropriately. Staff communicated with residents appropriately, used discretion when discussing medical conditions or treatment, and used residents’ preferred names. Staff sought the resident’s permission before entering their room. All bathrooms, showers, toilets, and single bedrooms had locks with an override function on the inside of the door, unless there was an identified risk to a resident. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

In St. Aidan’s ward, the residents’ privacy and dignity was not appropriately respected. The accommodation in St. Aidan’s ward consisted of two large dormitories and one single bedroom. The beds within the dormitories were located too close together, which limited residents’ access to personal space. The unoccupied space, within the dormitories, was used for storage. The dormitories were not gender specific. However, this was subsequently addressed following the inspection.

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

a) The beds within the dormitories in St. Aidan’s ward were located too close together.
b) The dormitories were used for storage in St. Aidan’s ward.
c) The dormitories were not gender specific in St. Aidan’s ward.

NON-COMPLIANT

Quality Rating: Requires Improvement
Risk Rating: HIGH
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 July 2018. The policy included all the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Appropriately sized communal rooms were provided by the approved centre. Sufficient spaces were provided for residents to move about, including outdoor spaces. Residents’ access to the garden in St. Aidan’s ward was restricted as the door was locked due to the requirement for resident supervision. Suitable furnishings and supports were provided to assist residents’ independence and comfort. Not all residents in the shared dormitories in St. Aidan’s ward had access to personal space, as the residents’ beds were located too close together. The shared dormitories in St. Aidan’s ward were also used to store items of equipment and additional ward supplies. There was not a sufficient number of toilets for the residents in St. Aidan’s ward. At the time of the inspection, nine male residents shared one toilet. A second toilet was inaccessible due to the clinical needs of one resident. The approved centre had a sluice room, cleaning room, and laundry room.

The approved centre had adequate lighting, heating, appropriate signage and sensory aids, and no excessive noise was noted. Hazards were appropriately identified and minimised. Ligature points were minimised to the lowest practicable level, based on risk assessment. A cleaning schedule was implemented. The approved centre was not clean, hygienic and free from offensive odours. The outdoor
spaces in Grangemore ward were littered with cigarette butts. Not all of the rooms were adequately ventilated and toilets in both wards were malodorous.

The approved centre was not kept in a good state of repair. Internal wall paint was peeling or chipped, and floor coverings were damaged in both units. The ceilings were damaged in three areas due to leaks, a corridor in Grangemore ward and in the sitting room and toilet in St. Aidan’s ward. While there was evidence that maintenance issues had been previously reported, the issues had not been resolved. The inspection team have since been provided with plans to address these maintenance issues.

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

a) The approved centre was not clean as the outdoors spaces were littered with cigarette butts and some of the toilets were malodorous, 22(1)(a).

b) The approved centre was not maintained in good structural and decorative condition as internal wall paint was peeling or chipped, floor coverings were damaged, and the ceilings were damaged in three areas due to leaks, 22(1)(a).

c) Not all of the rooms were adequately ventilated 22(1)(b).

d) A programme of routine maintenance and decoration of the premises was not developed or implemented, 22(1)(c).

e) Residents did not have access to personal space, as the beds within the dormitories were located too close together, 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 October 2018. The policy addressed requirements of the Judgement Support Framework, with the exception of the process for medication reconciliation.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: The MPARs for ten of the residents were inspected. A record of allergies or sensitivities to any medication was documented for all. The generic names of medications and preparations were written in full with dedicated spaces for routine medications, once-off medications, and “as required” (PRN) medications. The frequency of administration, the dosage, and the administration route for medications were recorded.

Medication was administered in accordance with the directions of the prescriber and the pharmacist, where relevant. The expiration date of the medication was checked prior to administration, and good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. Where a resident refused medication, this was documented in the MPAR and clinical file and communicated to medical staff. Controlled drugs were checked by two staff members against the delivery form and recorded in a controlled drug book. Directions to crush medication were evident in two of the ten MPARs reviewed. These had been ordered by the resident’s medical practitioner and documented in the respective MPARs. A documented reason as to why the medication was to be crushed was not evident in either clinical file.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a daily log of fridge temperatures was maintained. Scheduled controlled drugs were secured separately from medication. Medication dispensed to residents was stored securely in a locked trolley and/or medication administration cupboards. Medication storage areas were dry and clean and not used for the storage of food and drink. A system of
stock-rotation was implemented. An inventory of medications had not been conducted on a monthly basis.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring and evidence of implementation pillars.
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 policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in March 2019. It also had an associated safety statement, dated January 2019. The policy and safety statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- The content of the health and safety statement
- Response to sharps or needle stick injuries
- Availability of staff vaccinations or immunisations

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

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

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

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

NON-COMPLIANT

Quality Rating  Requires Improvement
Risk Rating  HIGH

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Clear signs were displayed in prominent positions, where CCTV cameras, were located throughout the approved centre. Residents were monitored solely for the purposes of ensuring the health, safety, and welfare of that resident. The usage of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras, which were used to observe a resident, did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV cameras which were used to observe a resident were capable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the closed circuit television (CCTV) was incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form, 25(1)(d).
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 March 2019. 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 staff planning requirements to address the number and skill mix of staff appropriate to the size and layout of the approved centre.
- The roles and responsibilities in relation to staff training processes within the approved centre.
- Orientation and induction training for staff.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.

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

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

Evidence of Implementation: There was an organisational chart identifying the leadership and management structure and lines of authority and accountability of staff in the approved centre. A planned and actual staff rota, showing the staff on duty during the day and night, was in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in
charge at all times. The number of staff was not sufficient to address the assessed needs of the residents. The nursing staff complement on Grangemore ward was noted to be one nurse short on three occasions within a four week period.

Staff had been recruited and selected in accordance with the approved centre’s policy and procedure for recruitment. All staff had been vetted as is required. Staff had the appropriate qualifications to do their jobs. There was a written staffing plan for the approved centre that addressed the skill mix, competencies, number and qualifications of staff. The staffing plan did not take into consideration the assessed needs of the resident group profile of the following: size and layout of the approved centre, level of acuity of psychiatric illness, age profile of the residents, the length of stay of the residents, the physical care needs of the residents, challenging behaviour exhibited by the residents, level of dependency and need for supervision of residents, or the number of beds available. It did address the required number of staff on duty at night to ensure safety of residents in the event of a fire or other emergency.

Where agency staff were used there was a comprehensive contract between the approved centre and the agency used. This set out the agencies responsibilities in relation to vetting of staff; confirmation of registration; confirmation of indemnity; and confirmation of staff training. An annual staff training plan had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed for staff. Not all health care professionals had up to date training in fire safety, Basic Life Support, Management of violence and aggression, The Mental Health Act and Children First, as set out in the table below:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (48)</td>
<td>39</td>
<td>81%</td>
<td>39</td>
<td>81%</td>
<td>48</td>
</tr>
<tr>
<td>Medical (7)</td>
<td>7</td>
<td>100%</td>
<td>7</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Occupational Therapist (3)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Social Worker (2)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Psychologist (3)</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>66%</td>
<td>3</td>
</tr>
</tbody>
</table>

Other staff training included manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, resident rights and recovery–centred approaches to mental health care and treatment. All staff training was documented and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education.

The following is a table of clinical staff assigned to the approved centre.
The approved centre was non-compliant with this regulation for the following reasons:

a) The number of staff was not sufficient to meet the resident needs as the nursing staff complement on Grangemore ward was one nurse short on three occasions within a four-week period, 26(2).

b) Not all healthcare professionals were trained in Basic Life Support, fire safety, management of violence and aggression and Children First, 26(4).

c) Not all healthcare professionals were trained in the Mental Health Act, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in May 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 the record review requirements.

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

Monitoring: Resident records were not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were not in good order, constructed, maintained, and used in line with national guidelines and legislative requirements. Records were observed to be bulky and had loose pages. The records were appropriately secured and where possible, were physically stored together.

A record had been initiated for every resident in the approved centre, and these were reflective of residents’ current status and the care and treatment being provided. Resident records were maintained through the use of an identifier that was unique to the resident, along with the resident name, address, and date of birth. Not all resident records were developed and maintained in a logical sequence and staff had difficulty retrieving some information.
Records were written legibly and contained factual, consistent, and accurate entries. Each entry included the date, noted the time using the 24-hour clock and was followed by a signature. Only authorised staff made entries in residents’ records, or specific sections therein. Not all entries made by an intern student nurse had been countersigned by a registered nurse. Residents’ access to their records was managed in accordance with Data Protection Acts.

Documentation relating to 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 non-compliant with this regulation for the following reasons:

a) Not all clinical files were maintained in good order as some were bulky and contained loose pages, 27(1).

b) Not all clinical entries were complete as some had been signed by an intern student nurse and were not countersigned by a registered nurse, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was not 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 non-compliant with this regulation because the registered proprietor did not ensure that the register was up-to-date, 28(1).
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 June 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for disseminating operating policies and procedures, either in electronic or hard copy
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated 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 relevant stakeholders. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Operating policies and procedures were communicated to all relevant staff.

All of the operating policies and procedures, required by the regulations, had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but had not been removed from possible access by staff. Generic policies in use were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre had a written statement to this effect, adopting the policies in question.

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

COMPLIANT
Quality Rating Satisfactory
(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 June 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 not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

**Evidence of Implementation:** The approved centre had provided private facilities to support the Mental Health Tribunal process. Adequate resources were available to support the Mental Health Tribunal process. Staff assisted and supported patients to attend and participate in the process, where necessary.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed and therefore actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated individual with responsibility for dealing with all complaints, who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy and the resident information booklet. The approved centre’s management of the complaints processes was well publicised. The registered proprietor ensured that the quality of the service or care and treatment of a resident was not adversely affected by reason of a complaint being lodged.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All minor complaints were documented and dealt with by staff locally. The inspection was informed that no complaints that had been made to the nominated complaints officer for the wider service through the Your Service Your Say process since the last 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 training and education and monitoring pillars.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The risk management policy had been implemented throughout the approved centre. Responsibilities were allocated at management level to ensure the effective
implementation of risk management. The person with responsibility for risk was known by all staff in the approved centre. Risk management procedures actively sought to reduce identified risks to the lowest practicable level of risk. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, on discharge, and in conjunction with medication requirements or administration. There was no evidence for the transfer of one resident that a risk assessment had been completed. The multidisciplinary teams were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Incidents in the approved centre were recorded and risk-rated using the National Incident Management System. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. The approved centre had an emergency plan that incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
<table>
<thead>
<tr>
<th>Regulation 33: Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Evidence of Implementation: Five clinical files relating to mechanical restraint were reviewed on inspection. There was evidence that lap-belts, for enduring risk of harm to self or others, were only used to address an identified clinical need. In three of the clinical files, there was insufficient documentary evidence to indicate that mechanical restraint was only used when less restrictive alternatives were deemed unsuitable. In these three clinical files, there was no record of the less restrictive alternatives that were implemented without success. Mechanical restraint was ordered by a registered medical practitioner, under supervision of consultant psychiatrist or by the duty consultant psychiatrist acting on his/her behalf in all five clinical files.

All of the clinical files contained a record of the following:

- The type of mechanical restraint.
- The situation in which mechanical restraint was being applied.
- The duration of the order.

Furthermore, one of the clinical files did not indicate the duration of the mechanical restraint and four of the clinical files did not document a review date.

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

a) Three clinical files did not indicate that mechanical restraint was only used when less restrictive alternatives were deemed unsuitable, 21.2.
b) Three clinical files did not record that less restrictive alternatives were implemented without success, 21.5(b).
c) One clinical file did not specify the duration of the mechanical restraint, 21.5(e).
d) Four clinical files did not specify a review date, 21.5(g).
9.0 Inspection Findings – Mental Health Act 2001

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

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

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.

   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

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

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

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

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

INSPECTION FINDINGS

The clinical file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had assessed the patient’s capacity to consent to receive treatment and that the patient was unable to consent.

A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed and documented the following details:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient including:
  - The nature and purpose of the medications.
  - Effects of medications, including risks and benefits and any views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
– Approval by a consultant psychiatrist
– Authorisation by a second consultant psychiatrist

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

10.0 Inspection Findings – Codes of Practice
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 May 2018. It addressed the following:

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

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. The record was available to the inspector.

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

Evidence of Implementation: The clinical file relating to an episode of physical restraint was inspected. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. With the resident’s consent, the next of kin or representative had been informed of the use of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident’s needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the resident’s clinical file.

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

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in October 2018 included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in May 2018 included all of the 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 not been completed on the implementation of and adherence to the admission, transfer and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident’s family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged evidenced a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to the relevant agencies and a comprehensive discharge summary had been sent within 14 days that detailed diagnosis, prognosis and medication. As applicable, a follow up appointment had been arranged for the resident.

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

a) The approved centre had not audited their admission, transfer and discharge processes, 4.19.

b) The approved centre did not comply with Article 18 of the Regulations in respect of information transfer, 30.1.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 16: Therapeutic Services and Programmes

<table>
<thead>
<tr>
<th>Reason ID : 10000218</th>
<th>Description</th>
<th>Corrective Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The registered proprietor did not ensure that each resident in St. Aidan's ward had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16(1).</td>
<td>Additional occupational therapy and psychology resources have been allocated to the therapeutic programme in St. Aidan's. A Multidisciplinary Therapeutic Programme Working Group has also been established including unit staff and MDT staff. Initially this group met on a weekly basis to establish the group and programme, as the programme is now further developed the group meets fortnightly and aims to meet monthly going forward to continue a timely.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Achievable and Realistic. These actions are in place currently and will be ongoing.</td>
<td>25/07/2019</td>
<td>The MDT Therapeutic Programmes Working Group - consisting of MDT and unit staff.</td>
</tr>
</tbody>
</table>
review of the programme and address any challenges. Minutes from the most recent meeting attached.
Since April 2019, the therapeutic programme has delivered a range of group programmes based on the assessed needs of the service users including a social group, therapeutic gardening, therapeutic dog visits, requests group, yoga, creative movement group, craft group and music. Statistics are maintained of all attendances (see attached) and the time table is frequently reviewed and updated - a copy of the current time table is attached. Groups are run for a set period of time,
then reviewed regarding appropriateness for the service users and their preferences - this is then discussed at the MDT Therapeutic Programmes Working Group and a decision is made as to whether to continue the group or discontinue. An activity requests book has been put in place on the unit, any activity requests from service users and family members is recorded in the book and discussed at the Working Group to identify suitability. A range of individual therapeutic interventions from clinical staff including 1:1 occupational therapy to support occupational engagement and wellbeing and 1:1 psychology focused
on reminiscence behavioural activation is taking place. Statistics are maintained of any individual work. A private occupational therapist provides seating and postural management assessment and intervention for the service users in St. Aidan’s.

| Preventative Action | The MDT Therapeutic Programmes Working Group is responsible for monitoring the development and the delivery of the Therapeutic Programme. This group meets fortnightly currently with a plan to meeting monthly on an ongoing basis as the programme has now been established. This group is multidisciplinary in | Monthly minutes, statistics and quarterly audit. | Completed | 25/07/2019 | The MDT Therapeutic Programmes Working Group - consisting of MDT and unit staff. QPSC |
membership and reports to QPSC who meet monthly to review progress. Audits and statistics are maintained to monitor progress and adherence.

<table>
<thead>
<tr>
<th>Reason ID : 10000219</th>
<th>The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>The therapeutic needs of service users is recorded in their ICP which includes the outcome of the service users' Pool Activity Level (PAL) assessment (The PAL is recommended by the NICE Guidelines for Dementia, 2018) and other indicated assessments. ICP meetings are attended by unit staff and members of the MDT. Suitable activities for the therapeutic programme are identified and</td>
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<td>Achievable/Realistic</td>
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<td>Post-Holder(s)</td>
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<tr>
<td></td>
<td>Yes - a protocol is developed for each activity. For each attendance and non-attendance is recorded in the service users file. Statistics, time table and audit are in place.</td>
</tr>
<tr>
<td></td>
<td>Yes - these corrective actions are already in place.</td>
</tr>
<tr>
<td></td>
<td>The MDT Therapeutic Programmes Working Group QPSC - as a monitoring body</td>
</tr>
</tbody>
</table>
trialed with service users. Each activity is researched to identify the evidence base for using the activity with service users who have dementia and/or other mental health conditions. A folder is maintained of the evidence base for the activities which is available on the unit. After each group service users are asked for feedback and this is recorded in the service user's clinical file. One of the occupational therapists completed training in July 2019 in the delivery of the Imagination Gym programme. This is an evidence based programme specifically designed for service users with dementia, and is being rolled out in...
August 2019. After a pilot period of five sessions this programme will be reviewed in relation to the benefits for service users in St. Aidan's.

In the current time table activities are tailored to restore and maintain the optimal levels of physical and psychosocial functioning for example the Reminiscence Activation Therapy specifically aims to support cognitive awareness and maintaining identity (further information attached); Creative movement encourages physical activity, cognitive functioning and socialisation; Music supports socialisation, mood enhancement, communication, and enjoyment.
A sample of an activity group protocol and poster is attached.

| Preventative Action | MDT staff attend ICP meetings in St. Aidan's. The PAL has been completed with each POLL service user in St. Aidan's. The MDT Therapeutic Programmes Working Group has been established and has responsibility for identifying and delivering appropriate activities for service users in St. Aidan's based on their assessed needs. Staff developing the programmes are required to research the evidence base for the activity/programme and include this in the Therapeutic Programmes Folder which is available on the unit. | Service user needs will be monitored via their individual ICP. Statistics will be maintained of the therapeutic groups and attendances. Individual attendances and non-attendances are recorded in the service user’s clinical file. Minutes are kept of both the MDT Therapeutic Programmes Working Group and QPSC meetings. An evaluation process is in place to monitor appropriateness and benefits of activity, this evaluation will be formalised into the minutes of the MDT Therapeutic Programmes Working Group. | Yes | 30/08/2019 | The MDT Therapeutic Programmes Working Group QPCS |
| Any service user therapeutic needs which have been identified in the ICP and cannot be met by the current programme/staff can be escalated to the monthly QPSC meeting for action. Quarterly audit will support an ongoing review of the programme to ensure that it is meeting service users assessed needs. The next audit is scheduled for August 2019. Further training is scheduled in August 2019 for occupational therapy staff in the use of sensory strategies which will support the further development of sensory interventions and utilisation of the sensory room for the service users in St. Aidan’s. | Audits will be carried out quarterly and results will be discussed at the MDT Therapeutic Programmes Working Group and QPSC meetings - this will be recorded in the minutes. The Therapeutic Programmes folder will be maintained on the unit which outlines the range of activities and programmes available and the evidence base for same. All 1:1 assessments and interventions are recorded in the clinical file. |  |  |
### Regulation 18: Transfer of Residents

**Reason ID: 10000220**

When a resident was transferred from the approved centre for treatment in another hospital, the registered proprietor of the approved centre from which the resident was being transferred did not ensure that all relevant information about the resident was provided to the receiving hospital, 18(1).

<table>
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<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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<tbody>
<tr>
<td>The Transfer Form has been reviewed to include all required information in line with regulation 18, the Code of Practice and the Judgment support framework. This transfer form will be presented in a triplicate Transfer booklet. One copy of the form will be filed in the HCR, the second copy will be provided to the receiving hospital and the third copy will be stored in the on site transfer log.</td>
<td>Following implementation of the triplicate book, an audit of transfers will be completed and governance will be provided by QPSC. Any non-compliance issues raised through the audit process will be addressed.</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>CNM</td>
<td></td>
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</tbody>
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<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>Following implementation of the triplicate book an audit will be completed and governance will be provided by QPSC.</td>
<td>An audit will be completed once the Transfer Booklet has been implemented and governance will be provided by QPSC. Any non</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>CNM</td>
<td></td>
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<tr>
<td>Any non compliance issues raised through the audit process will be addressed.</td>
<td></td>
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<tr>
<td>compliance issues raised through the audit process will be addressed.</td>
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Regulation 19: General Health

Regulation 19: General Health

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Description</th>
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<tbody>
<tr>
<td>10000221</td>
<td>The six monthly physical assessments were incomplete. Not all of the assessments included smoking status, nutritional status, BMI, weight and waist circumference, dental assessment and an assessment of blood lipids, 19(1).</td>
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</tbody>
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<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>The General Health Assessment Form has been amended to include all requirements under regulation 19 General Health. The implementation of this revised form has ensured that smoking status, nutritional status, BMI, weight and waist circumference, dental assessment and an assessment of blood lipids, 19(1) and all other required assessments are included in the six monthly assessments. A memo has been sent to remind NCHD's that all sections of the six monthly general health</td>
<td>The General Health Assessment Form has been amended to include all requirements under regulation 19 General Health. The implementation of this revised form has ensured that smoking status, nutritional status, BMI, weight and waist circumference, dental assessment and an assessment of blood lipids, 19(1) and all other required assessments are included in the six monthly assessments. A memo has been sent to remind NCHD's that all sections of the six monthly general health</td>
<td>An annual General Health Audit will take place as part of the Approved Centre's Audit Schedule.</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>Consultant Psychiatrist.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The General Health Assessment Form has been amended to include all requirements under regulation 19 General Health. The implementation of this revised form has ensured that smoking status, nutritional status, BMI, weight and waist circumference, dental assessment and an assessment of blood lipids, 19(1) and all other required assessments are included in the six monthly assessments. A memo has been sent to remind NCHD’s that all sections of the six monthly general health assessments are to be completed.</td>
<td>Achievable</td>
<td>30/08/2019</td>
<td>Consultant Psychiatrist.</td>
<td></td>
</tr>
</tbody>
</table>
**Regulation 21: Privacy**

<table>
<thead>
<tr>
<th>Reason ID : 10000222</th>
<th>The beds within the dormitories in St. Aidan’s ward were located too close together.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The additional unused beds and clutter were removed from the dormitory. The steps to address this action commenced during inspection. This action was completed on the 2/4/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The beds have been rearranged to provide adequate space for each resident.</td>
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</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000223</th>
<th>The dormitories were used for storage in St. Aidan's ward.</th>
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<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>During inspection these items were removed from the dormitory. This</td>
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<tr>
<td>Action</td>
<td>Details</td>
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<tr>
<td>Preventative Action</td>
<td>The CNM now manages the stock control and staff have been instructed to use the store room only. A safety walkthrough has commenced and will be carried out quarterly with governance provided by QPSC.</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>The dormitories were made gender specific on the 02/04/2019. E-mail was sent to the MHC to confirm this change had taken place.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The Dormitories will remain gender specific. A quarterly walk through review has commenced and oversight will be provided by QPSC.</td>
</tr>
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</table>
### Regulation 22: Premises

**Reason ID : 10000225**

The approved centre was not clean as the outdoors spaces were littered with cigarette butts and some of the toilets were malodorous, 22(1)(a).

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<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The outdoor spaces were cleaned during inspection, the floor covering in the toilet was changed following inspection. A cleaning schedule to be agreed with grounds staff.</td>
<td>CNM will check the outdoor space daily and follow up with grounds staff as necessary.</td>
<td>Achievable and Realistic</td>
<td>30/08/2019</td>
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**Preventative Action**

A cleaning schedule to be agreed with grounds staff. CNMs will observe outdoor spaces daily and report any issues to ground staff. CNM will check the outdoor space daily and follow up with grounds staff as necessary.

| Achievable and Realistic | 30/08/2019 | Service Manager |

**Reason ID : 10000226**

The approved centre was not maintained in good structural and decorative condition as internal wall paint was peeling or chipped, floor coverings were damaged, and the ceilings were damaged in three areas due to leaks, 22(1)(a).

<table>
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<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The Ceiling identified by the MHC have been repaired. Grangemore has been painted, the replacement of floors has commenced in Grangemore.</td>
<td>Confirmation from maintenance that the work has been completed and works to be verified by CNM.</td>
<td>Achievable</td>
<td>01/09/2019</td>
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AC0033 Grangemore Ward & St Aidan’s Ward, St Otteran’s Hospital  
Approved Centre Inspection Report 2019  
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### Preventative Action

**Maintenance log managed by the CNM.**  
All maintenance issues will be reported in a timely manner. Any issues unresolved shall be communicated to service management and escalated to QPSC.

**Maintenance log managed by the CNM checked weekly, oversight provided by QPSC.**

**Achievable**

<table>
<thead>
<tr>
<th>Post-Holders</th>
<th>Date</th>
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<tr>
<td></td>
<td>01/09/2019</td>
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### Corrective Action

**Not all of the rooms were adequately ventilated 22(1)(b).**

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<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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</thead>
<tbody>
<tr>
<td>All windows are functional and opened as required.</td>
<td>Any barriers to adequate ventilation are escalated to technical services</td>
<td>Achievable</td>
<td>29/07/2019</td>
<td>CNM</td>
</tr>
</tbody>
</table>

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### Preventative Action

**Any barriers to adequate ventilation are escalated to technical services**

**Any issues regarding ventilation are addressed at the community meetings.**

**Achievable**

<table>
<thead>
<tr>
<th>Post-Holders</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29/07/2019</td>
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</tbody>
</table>

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### Corrective Action

**A programme of routine maintenance and decoration of the premises was not developed or implemented, 22(1)(c).**

<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>A programme of routine maintenance is under development. In the interim, a maintenance checklist has been</td>
<td>Maintenance governance checklist reviewed at QPSC. The development of a Programme of Maintenance will be</td>
<td>Achievable if cooperation and agreement is achieved between Technical Services, UHW and WWMHS Management.</td>
<td>30/10/2019</td>
<td>CNM Service Manager Technical Services</td>
</tr>
</tbody>
</table>

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developed for the approved centre. a priority for QPSC and Service Management.

### Preventative Action

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Achievable if cooperation and agreement is achieved between Technical Services, UHW and WWMHS Management.</th>
<th>Date</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance governance checklist reviewed at QPSC. Any difficulties resolving maintenance issues are escalated through QPSC to Service Management.</td>
<td></td>
<td></td>
<td></td>
<td>CNM QPSC Service Management</td>
</tr>
<tr>
<td>Maintenance governance checklist reviewed at QPSC. Programme of Maintenance will be evident when in place.</td>
<td></td>
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### Corrective Action

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<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The unused beds have been removed to provide sufficient personal space for residents. This was completed in April 2019.</td>
<td>The verification of this action was emailed to the MHC.</td>
<td>Achieved</td>
<td>02/04/2019</td>
<td>CNM</td>
</tr>
</tbody>
</table>

### Preventative Action

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable and Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents are moving to a new premises in Jan 2020. In the interim, no beds or other items will be stored in the dormitory. Residents’ personal space will be maintained. On admission the CNM carries out a walk through Audit will be carried out quarterly with governance provide by QPSC.</td>
<td></td>
<td>Achievable and Realistic</td>
<td>02/04/2019</td>
<td>CNM</td>
</tr>
<tr>
<td>site specific assessment to allocate the appropriate bed space.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 25: Use of Closed Circuit Television

#### Reason ID: 10000230

The registered proprietor did not ensure that the closed circuit television (CCTV) was incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form, 25(1)(d).

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A full review by Technical services and outside contractor Park 100 security has been completed on the 28th May 2019. The CCTV is operating as per the regulation. An educational session has taken place titled understanding &quot;Live view icons&quot; for staff, in addition a daily spot check and record is maintained on the unit.</td>
<td>A record is maintained on the unit</td>
<td>Completed</td>
<td>28/05/2019</td>
<td>CNM Technical Services</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>National recruitment campaign and local bespoke campaign in progress. All graduate nurses are offered permanent contracts. Negotiations ongoing in relation to skill mix with staff representative bodies. Daily allocation of staff based service needs and risk assessment. Both contracted and uncontracted agency nurses resourced to fill gaps in roster.</td>
<td>Daily review of staffing levels by allocations officer with oversight by QPSC</td>
<td>Ongoing recruitment and retention challenges impact on WWMHS's ability to fill nursing vacancies.</td>
<td>05/11/2019</td>
<td>Area Director of Nursing. Allocations Officer Assistant Director of Nursing.</td>
<td></td>
</tr>
</tbody>
</table>

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<td>Daily review of staffing levels by allocations officer with oversight by QPSC</td>
<td>Ongoing recruitment and retention challenges impact on WWMHS's ability to fill nursing vacancies.</td>
<td>05/11/2019</td>
<td>Area Director of Nursing. Allocations Officer and Assistant Director of Nursing.</td>
<td></td>
</tr>
</tbody>
</table>

Regulation 26: Staffing
Reason ID: 10000231

The number of staff was not sufficient to meet the resident needs as the nursing staff complement on Grangemore ward was one nurse short on three occasions within a four-week period, 26(2).
Negotiations ongoing in relation to skill mix with staff representative bodies. Daily allocation of staff based service needs and risk assessment. Both contracted and uncontracted agency nurses resourced to fill gaps in roster.

**Reason ID : 10000232**

<table>
<thead>
<tr>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Heads of Discipline have been contacted to ensure all staff under their remit are up to date with their mandatory training.</td>
<td>Heads of Discipline asked to present training statistics to QPSC on a monthly basis for oversight.</td>
<td>Realistic</td>
<td>05/11/2019</td>
<td>Heads of Discipline</td>
</tr>
</tbody>
</table>

<table>
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<th>Time-bound</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Schedule of training available on P-drive for all mandatory training for all staff in relation to Fire Safety, Basic Life Support and Management of Violence and Aggression. Childrens First and Mental</td>
<td>Heads of Discipline asked to present training statistics to QPSC on a monthly basis for oversight. A service database is maintained to record all mandatory training.</td>
<td>Realistic</td>
<td>05/11/2019</td>
<td>Heads of Discipline</td>
</tr>
<tr>
<td>Health Act Training available online through HSELand.</td>
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</tbody>
</table>
### Regulation 27: Maintenance of Records

<table>
<thead>
<tr>
<th>Reason ID: 10000234</th>
<th>Not all clinical files were maintained in good order as some were bulky and contained loose pages, 27(1).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A dedicated administration staff member has been assigned to a weekly review of all health care records in the approved centre as of June 2019. Any loose pages or other issues have been rectified.</td>
<td>Nursing Metrics data collection has been expanded within the Approved Centre to monitor health care records on a monthly basis.</td>
<td>Completed. Monitoring is ongoing.</td>
<td>30/06/2019</td>
<td>Administrator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A dedicated administration staff member has been assigned to a weekly review of all health care records in the approved centre as of June 2019. Any future issues will be addressed as they arise.</td>
<td>Nursing Metrics data collection has been expanded within the Approved Centre to monitor health care records on a monthly basis.</td>
<td>Monitoring is ongoing.</td>
<td>30/06/2019</td>
<td>Administrator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000235</th>
<th>Not all clinical entries were complete as some had been signed by an intern student nurse and were not countersigned by a registered nurse, 27(1).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The files highlighted by the commission were reviewed and countersigned by RPN.</td>
<td>The metrics to monitor good record keeping is in progress</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>CNM, RPN, CPC</td>
</tr>
</tbody>
</table>
The NIMBI guidelines have been reviewed with nursing staff to ensure that all student entries are countersigned. The Clinical Placement Coordinator has discussed with students during reflective practice sessions.

| Preventative Action | A monthly Metric to monitor good record keeping with oversight by QPSC | The metrics to monitor good record keeping is in progress | Achievable | 30/09/2019 | CNM RPN CPC |
### Regulation 28: Register of Residents

<table>
<thead>
<tr>
<th>Reason ID: 10000236</th>
<th>The registered proprietor did not ensure that the register was up-to-date, 28(1).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A register of residents is now being maintained in line with the schedule. The register went live for St Otteran’s campus on the 18th July 2019 and is available to view on the P-Drive for all staff. A dedicated administrator has been assigned to update the Register of Residents on a daily basis. Nursing Staff are responsible for notifying the administrator of any changes to the resident population.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>An established practice is now in place to support with compliance managed by the CNMs in St Otteran’s and Register of Residents will be audited by the 30th August 2019. This will be reviewed and governance</td>
</tr>
</tbody>
</table>
supported by the Administration staff.

provided by the QPSC.
<table>
<thead>
<tr>
<th>Reason ID : 10000216</th>
<th>The approved centre had not audited their admission, transfer and discharge processes, 4.19.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>An audit for the approved centres admission transfer and discharge process has been completed April 2019.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>An audit schedule is now in place which includes audits of Admission, Transfer and Discharge processes. Findings will be presented to QPSC. Quality improvement plans will be implemented where required.</td>
<td>Achievable.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Schedule of yearly audit which includes audits of Admission, Transfer and Discharge processes is in place with oversight by QPSC. Transfer form has been updated, approved by QPSC.</td>
</tr>
<tr>
<td>Audit results reviewed by QPSC. A post transfer retrospective review of each transfer is carried out in the approved centre. Updated transfer form due for implementation end of August 2019.</td>
<td>Achievable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000217</th>
<th>The approved centre did not comply with Article 18 of the Regulations in respect of information transfer, 30.1.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The transfer form has been reviewed to include all required</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>An audit of transfers will be completed once the new</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The transfer form has been reviewed to include all required information in line with regulation 18, the Code of Practice and the Judgment support framework. This transfer form will be presented in a triplicate Transfer Booklet. One copy of the form will be filed in the HCR, the second copy will be provided to the receiving hospital and the third copy will be stored in the on site transfer log.</td>
</tr>
</tbody>
</table>
and the third copy will be stored in the on site transfer log.
Rules Governing the Use of Mechanical Means of Bodily Restraint

Reason ID: 10000237

Three clinical files did not indicate that mechanical restraint was only used when less restrictive alternatives were deemed unsuitable, 21.2. Three clinical files did not record that less restrictive alternatives were implemented without success, 21.5(b). One clinical file did not specify the duration of the mechanical restraint, 21.5(e). Four clinical files did not specify a review date, 21.5(g).

<table>
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</thead>
<tbody>
<tr>
<td></td>
<td>Use of Mechanical Restraint forms are currently being reviewed to ensure documentation of all requirements within the Rules governing the Use of Mechanical Restraint including: less restrictive alternatives were deemed unsuitable 21.2. that less restrictive alternatives were implemented without success, 21.5(b). the duration of the mechanical restraint, 21.5(e). a review date, 21.5(g).</td>
<td>Mechanical restraint forms will be audited quarterly with ICP audits to ensure compliance with all requirements of the Rules of Mechanical Restraint. Oversight by the QPSC. Any non compliance identified will be addressed.</td>
<td>Achievable and Realistic</td>
<td>02/09/2019</td>
<td>Consultant Psychiatrist.</td>
</tr>
</tbody>
</table>

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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use of Mechanical Restraint forms are currently being reviewed to ensure</td>
<td>Mechanical restraint forms will be audited quarterly with ICP</td>
<td>Achievable</td>
<td>02/09/2019</td>
<td>Consultant Psychiatrist,</td>
</tr>
<tr>
<td>Compliance with the rules governing the use of mechanical restraint.</td>
<td>Audits to ensure compliance with all requirements of the Rules of Mechanical Restraint. Oversight by the QPSC. Any non compliance identified will be addressed.</td>
<td></td>
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</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.