Units 2, 3, 4 and Unit 8 (Floor 2), St Stephen's Hospital

ID Number: AC0036

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital
Sarsfield's Court
Glanmire
Co Cork

Conditions Attached: Yes

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

Registered Proprietor: HSE

Most Recent Registration Date: 1 March 2017

Inspection Team:
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Inspection Date: 3 – 6 September 2019
Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 4 – 7 September 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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

Date of Publication: Thursday 13 February 2020

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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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The approved centre served North Cork and was located seven kilometres from Cork city outside the village of Glanmire. The approved centre had 87 beds and comprised of four buildings co-located within the 117 acre grounds at St. Stephen’s Hospital and provided acute and continuing care. The North Cork area was served by three general adult sector teams. A Psychiatry of Later Life, and a Rehabilitation team, also admitted residents to the approved centre.

There was an improvement in compliance with regulations, rules and codes of practice since 2017: Compliance was 59% in 2017; 59% in 2018 and 70% in 2019. Non-compliance with Regulation 22: Premises was rated critical, despite a condition attached to registration with regard to this regulation. The approved centre had been non-compliant with seven regulations and codes of practice for three consecutive years. Six compliances with regulations were rated excellent.

Conditions to registration

There were three conditions attached to the registration of this approved centre at the time of inspection.

**Condition 1:** To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.

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

**Condition 2:** To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Finding on this inspection:** The approved centre was in breach of Condition 2 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.
Condition 3: To ensure a comprehensive risk management policy is implemented in the approved centre in adherence to Regulation 32(1) and (2), the approved centre shall submit a copy of their risk register to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 3.

Safety in the approved centre

- The ordering, storage and administration of medication was conducted in a safe manner.
- Food safety audits had been completed periodically and food was prepared in a manner that reduced risk of contamination, spoilage, and infection. Hygiene was maintained and there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food.

However:

- Not all staff were trained in the required mandatory training areas which included fire safety, basic life support, the Mental Health Act, and the management of violence and aggression.
- Minimisation of ligature points was not to the lowest practicable level, based on risk assessment.
- There were a number of deficits in the prescribing of medication.
- The lack of washing facilities on Unit 8 (Floor 2) and the potential impact on resident hygiene was a significant risk to infection control within the approved centre.

Appropriate care and treatment of residents

- Each resident had an individual care plan, which was multi-disciplinary and developed with the resident.
- Therapeutic services and programmes were provided and residents from all four units attended the Valley View day centre which was also located on the grounds of St. Stephen’s Hospital.
- Residents had undergone comprehensive physical health monitoring, which was fully documented in the clinical file. The approved centre had introduced and implemented a six-monthly physical examination proforma across the service.
- All residents’ records were physically stored together and secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements.

Respect for residents’ privacy, dignity and autonomy

- Where residents shared a room, bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas or, if they were, the windows had opaque glass. Noticeboards do not display resident names or other identifiable information.
- There were adequate spaces for residents to meet with visitors in private.
• Residents were appropriately dressed, maintained control of their possessions where possible and were free to communicate by phone, and mail.

• Physical restraint was carried out in accordance with the relevant code of practice.

• Seclusion was not used in the approved centre.

However:

In 2018, the inspection team found that the state of the premises was a critical risk, principally due to the inadequate maintenance of the buildings and the limited showering facilities relative to the number of residents on Unit 8. Corrective action plans to address these issues were authored by the service, however, they were not implemented. Consequently, in 2019, the inspection team found no improvement in the condition of the premises and rated the non-compliance of Regulation 22: Premises as a critical risk again in 2019.

• The approved centre was not kept in a good state of repair externally and internally. There was no documented programme of general or planned maintenance.

• The approved centre was not clean, hygienic or free from offensive odours, as toilets were observed to be dirty and malodourous.

• Residents in Unit 8 did not have access to a sufficient number of showers: there was one shower for 18 residents.

• The approved centre did not provide suitable furnishings to support resident independence and comfort: furnishings in a number of areas were dilapidated and in need of replacement.

• Residents in Unit 8 did not have adequate access to an outside space.

• Bathrooms, showers and single bedrooms had locks on the inside of the door as appropriate, however not all toilets could be securely locked from the inside. One toilet door was noted to have a lock on both the inside and outside of the door and therefore did not provide suitable privacy.

• Single room door observation panels in Units 3 and 8 were not suitably screened to protect the privacy and dignity of the resident within the room.

• Mechanical restraint in the form of lap-belts was used in the approved centre but not in accordance with the Rules Governing the Use of Mechanical Restraint.

Responsiveness to residents’ needs

• Residents were provided with a variety of wholesome and nutritious food, with menus approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Food, including modified consistency diets were presented in a manner that was attractive and appealing.

• Written information was provided about the approved centre, diagnoses and medication.

• There was a robust complaints procedure in place.

• Recreational activities were appropriately resourced and provided during the week and on weekends. These included TV, books, board games, yoga, exercise and relaxation classes, art and craft, regular outings, walks, horticulture, snooker, pitch and putt, and music groups.

Governance of the approved centre
• St Stephen’s Hospital was under the governance of North Cork Mental Health Services and within the overall governance of Cork Kerry Community Healthcare Organisation (CHO). St Stephen’s hospital had a bi-monthly management meeting.

• Regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer engagement. An advocate from the Irish Advocacy Network also regularly attended the approved centre to meet with residents. The area lead for mental health engagement was invited to attend the CHO Area Management team meeting on a monthly basis.

• Opportunities for further education were made available to staff.

However:

• In 2018, the inspection team found that the state of the premises was a critical risk. Corrective action plans to address these issues were provided by the service but were not implemented. Funding for the development of new showering facilities on Unit 8 was approved, but did not proceed. The meeting minutes from various governance meetings indicated that there was limited oversight and management of the project at both a local and an organisational level.

• Numerous maintenance issues were noted throughout the approved centre, and whilst many had been reported to the maintenance team, they had been awaiting repair for many months. Communication from the maintenance team was limited and nursing management had attempted to progress particular issues but with minimal results.

• There was a cycle of audit in the approved centre; however, there was no clear process for disseminating results to the wider multi-disciplinary team. The majority of audits were completed by the nursing, medical and pharmacy teams with little involvement from other disciplines. The quality of audits was variable and some audits offered limited analysis and vague action plans. Where corrective actions were identified, timeframes for action completion were not recorded. It was unclear if corrective actions were completed as this was also not recorded.

• The service did not undertake an annual training needs analysis and there was no clear system in place for monitoring the training needs across all disciplines.

• The lack of washing facilities on Unit 8 (Floor 2) and the potential impact on resident hygiene and dignity was a significant unidentified, unassessed and untreated risk within the approved centre. This was not documented in the local risk assessments, local risk register or the area risk register.
The following quality initiatives were identified on this inspection:

1. Introduction and implementation of a six-monthly physical examination proforma across the service.

2. Development of a medication prescribing aid by the Pharmacy department. This was circulated to medical and nursing staff.

3. Implementation of an electronic ordering system and the procurement of scanning equipment has improved the efficiency of dispensing and ordering medications in the pharmacy department.

4. Collaboration between the pharmacy department and the community care pharmacist, the primary Care Reimbursement Service and the Irish Palliative Care Pharmacy Group to work toward obtaining access for residents to hospital emergency drugs scheme at discharge. This would increase efficiency for patients to obtain a medical card prescription at discharge.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located seven kilometres from Cork city in a picturesque valley outside the small village of Glanmire. The approved centre comprised of four buildings co-located within the 117 acre grounds at St. Stephen’s Hospital. The hospital was originally built as a tuberculosis sanatorium in 1954, with each of the units facing a southerly direction, maximising sunlight into the wards. Residents from all four units attended the Valley View day centre which was also located on the grounds of St. Stephen’s Hospital. There were extensive walkways throughout the hospital grounds, as well as a pitch and putt club used by the local community. There was ample parking for visitors and staff.

The North Cork area was served by three general adult sector teams (Fermoy and Mitchelstown, Mallow and Charleville, Kanturk and Newmarket). A Psychiatry of Later Life, and a Rehabilitation team, also admitted residents to the approved centre. Each admitting team had responsibility for the care of their residents.

The approved centre had a total of 87 beds and comprised the following:

- **Unit 2** – 25 beds for Psychiatry of Later Life.
- **Unit 3** – 18 beds for the care of male residents with severe and enduring mental illness.
- **Unit 4** – 19 beds for acute admissions within the North Lee area.
- **Unit 8** (Floor 2) – in the main building, had 25 beds which provided care to residents with enduring mental illness and challenging behaviour.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>87</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>63</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>8</td>
</tr>
<tr>
<td><strong>Number of wards of court</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>51</td>
</tr>
<tr>
<td><strong>Number of patients on Section 26 leave for more than 2 weeks</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

St Stephen’s Hospital was under the governance of North Cork Mental Health Services and within the overall governance of Cork Kerry Community Healthcare Organisation (CHO). St Stephen’s hospital had a bi-monthly management meeting but there was no local quality and patient safety meeting. At an organisational level, there was a monthly Cork Management team meeting. There was also a newly established Quality and
Patient Safety Committee, which convened on a quarterly basis. Heads of Service or discipline attended all meetings.

At the time of inspection, there were 13 nursing staff vacancies; however, staffing levels across all units were effectively managed through the allocation of overtime hours and the employment of agency personnel. Management mitigated the potential impact to resident care by regularly employing agency staff nurses with knowledge of the wards to provide familiarity and continuity of care. This was supported by the staffing rotas which showed the same group of agency nurses employed as required. The risk associated with the nursing staff vacancy levels had been identified by the area management team and entered on the risk register. Two adult sector team consultant posts were also vacant due to recent retirement and, at the time of inspection, two locum consultants were employed within these positions. The process for recruitment to both posts had been escalated to the Public Appointments Commission.

Opportunities for further education were made available to staff and at the time of inspection, two staff members had completed a higher diploma in psychiatric nursing this year and another was due to commence the same course later this year. A local orientation programme was undertaken for all new staff commencing employment within the approved centre. There was no consistent in-service training programme for nursing staff in operation. Not all staff were trained in the required mandatory training areas which included fire safety, basic life support, the Mental Health Act, and the management of violence and aggression. The service did not undertake an annual training needs analysis and there was no clear system in place for monitoring the training needs across all disciplines. Overall, however, there was a marginal improvement in training completion rates compared to figures submitted in March 2019.

In 2018, the inspection team found that the state of the premises was a critical risk, principally due to the inadequate maintenance of the buildings and the limited showering facilities relative to the number of residents on Unit 8. Corrective action plans to address these issues were authored by the service; however, they were not implemented. Consequently, in 2019, the inspection team found no improvement concerning the premises. Whilst funding for the development of new showering facilities on Unit 8 was approved, it was unclear why plans for redevelopment did not proceed. The meeting minutes from various governance meetings indicated that there was limited oversight and management of the project at both a local and an organisational level. Numerous maintenance issues were noted throughout the approved centre, and whilst many had been reported to the maintenance team, they had been awaiting repair for many months. Communication from the maintenance team was limited and nursing management had attempted to progress particular issues but with minimal results.

A cycle of audit was implemented within the approved centre, however, there was no clear process for disseminating results to the wider multidisciplinary team. The majority of audits were completed by the nursing, medical and pharmacy teams with minimal involvement from other disciplines. The quality of audits was variable and some audits offered limited analysis and vague action plans. Where corrective actions were identified, timeframes for action completion was not recorded. It was unclear if corrective actions were completed as this was also not recorded.

Regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer engagement. Complaints and compliments were reviewed periodically at the monthly Cork Mental Health Management
team meeting. An advocate from the Irish Advocacy Network also regularly attended the approved centre to meet with residents. The advocate also met with the assistant director of nursing every six weeks to provide feedback. At an organisational level, the area lead for mental health engagement was invited to attend the CHO Area Management team meeting on a monthly basis.

3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X High</td>
<td>X Critical</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X High</td>
<td>X Critical</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X Critical</td>
<td>X Critical</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✔ High</td>
<td>✔</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X High</td>
<td>X Moderate</td>
<td>X Low</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✔ High</td>
<td>X Low</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>X High</td>
<td>X Critical</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>X Low</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X High</td>
<td>X Low</td>
<td>X Moderate</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
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<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
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<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
</tr>
</tbody>
</table>
4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>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.

Six residents met with the inspection team. All residents were very complimentary to staff. The majority of residents thought the food was of a very high quality. The majority of residents were familiar with the multidisciplinary team. One resident stated that she would prefer not to reside on a mixed gender unit.

Three resident surveys were completed and returned to the inspection team. All residents had received information about their diagnosis, care and treatment and understood their care plan. Residents reported that privacy and dignity were respected by staff. Two residents indicated that there was not enough activities during the day. On a scale of one to ten, with one being poor and ten being excellent, residents rated their overall experience of care and treatment between eight and nine.
6.0 Feedback Meeting

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

- Area Administrator
- Assistant Director of Nursing, two present
- Area Director of Nursing
- Clinical Director
- Clinical Nurse Manager 2, four present
- Executive Clinical Director
- Head of Service (Cork and Kerry)
- Occupational Therapy Manager
- Principal Clinical Psychologist
- Senior Pharmacist
- Social Work Team Leader

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There were a minimum of two resident identifiers used, which were appropriate to the resident group profile and individual residents’ needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. Identifiers included resident name and photograph in the long-stay units (Units 2, 3 and 8) and resident name and date of birth in the admissions unit (Unit 4). An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Identifiers were appropriate to the residents’ communication abilities and were person specific. Appropriate identifiers and alerts were used to alert staff to residents with the same or a similar name. Unit 4 used a distinct sticker system to alert to similar resident names.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in December 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents in the approved centre were provided with a variety of wholesome and nutritious food, with menus approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Food, including modified consistency diets were presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition. Residents had access to hot and cold drinks and to safe, fresh drinking water. Hot meals were provided on a daily basis.

The St. Andrew’s Nutrition Screening Instrument was used in the assessment of resident nutritional needs. Weight charts were implemented, monitored, and acted upon for residents, where appropriate. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindications with medication. Nutritional and dietary needs were assessed and addressed in residents’ individual care plans and the dietary needs of residents with special dietary needs were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Food was prepared in a manner that reduced risk of contamination, spoilage, and infection. Hygiene was maintained to support food safety requirements. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Appropriate protective and catering equipment was used during the catering process. Appropriate hand-washing areas were provided for catering services. Residents were provided with crockery and cutlery that addressed their specific needs.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in December 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. A record of residents wearing nightclothes during the day was maintained and monitored. No residents were wearing nightclothes at the time of inspection.

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in December 2018. The policy included all requirements of the Judgement Support Framework.

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

Monitoring: Documented analysis had not been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents were entitled to bring personal possessions with them and were safeguarded if the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident’s monies, valuables, personal property, and possessions, as necessary. A resident property checklist was compiled on admission and updated as needed. The checklist was kept separately to the resident’s individual care plan (ICP) and was available to the resident.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained and where possible counter-signed by the resident or their representative.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in December 2018. The policy included all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were appropriately resourced and provided during the week and on weekends. These included TV, books, board games, yoga, exercise and relaxation classes, art and craft, regular outings, walks, horticulture, snooker, pitch and putt, and music groups. Information was provided to residents in an accessible format, which was appropriate to their individual needs, and included the types and frequency of appropriate recreational activities available within the approved centre. Recreational activities programmes are developed, implemented, and maintained for residents, with resident involvement through community meetings.

Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Resident decisions on whether or not to participate in activities were respected and documented, as appropriate. Opportunities were provided for both indoor and outdoor exercise and physical activity and communal areas provided for recreational activity were appropriate. Though there was limited outdoor space in Unit 8, residents could be accompanied to Valley View day centre for outdoor recreational activities as requested. Daily outdoor walks were also facilitated as appropriate. Documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file, as appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in December 2018. The policy addressed requirements of the Judgement Support Framework, with the exception of the roles and responsibilities in relation to the support of residents’ religious practices.

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as is practicable. There were facilities provided within the approved centre for residents’ religious practices and residents had access to multi-faith chaplains and local religious services, for which they were supported in attending, if deemed appropriate following a risk assessment. Unit 2 had a mass every Sunday, while Unit 3 had regular visits by a priest, as well as set days for a regular mass. Unit 4 had a monthly mass.

Care and services provided within the approved centre were respectful of the residents’ religious beliefs and values, and any specific religious requirements were clearly documented. The resident was 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 processes pillar.
Regulation 11: Visits

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.
(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.
(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.
(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.
(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.
(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in December 2018. The policy and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The availability of appropriate locations for resident visits
- 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: There were no restrictions on visits at the time of inspection. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were displayed publicly and were appropriate and reasonable. Apart from mealtimes, visiting times were unrestricted. Each unit had a designated visiting room, which was suitable for visiting children. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety and this was communicated to all relevant individuals publicly.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 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 December 2018. The policy and procedures addressed requirements of the Judgement Support Framework, with the exception the assessment of resident communication needs.

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet and telephone, unless otherwise risk-assessed with due regard to the residents’ well-being, safety, and health. Portable telephones were available in the units. 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. There were no restrictions on residents’ communications at the time of inspection. Where applicable, the clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: One file relating to a search of a resident was inspected. Risk was assessed prior to the search, appropriate to the type of search being undertaken, and resident consent was sought. The request for consent and the received consent were documented and the resident was informed by those implementing the search of what was happening during the search and why. A minimum of two clinical staff were in attendance and due regard to the resident’s dignity, privacy, and gender was implemented; at least one of the staff members conducting the search was the same gender as the resident being searched.
A written record of every search of a resident and every property search was available, and this included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The resident search policy and procedure was communicated to all residents. There had been no environmental searches since the last inspection.

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had written operational policies and protocols in relation to care of the dying and in relation to an unexpected death. The policies were last reviewed in December 2018. The policies and protocols addressed requirements of the Judgement Support Framework, with the exception of the process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

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

**Monitoring:** End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. There had been no sudden or unexpected deaths requiring systems analysis in the approved centre since the last inspection. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

**Evidence of Implementation:** A file relating to the death of one resident was inspected. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs and this was documented in the resident’s individual care plan (ICP). Religious and cultural practices were respected, insofar as is practicable and the privacy and dignity of residents was protected: the resident was accommodated in a single room.

Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care, as were staff and other residents following the death. Advance directives relating to end of life care as well as DNAR orders and associated documentation were evidenced in the clinical file. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon was is practicable and, in any event, no later than 48 hours of the death.
The sudden death of a resident was managed in accordance with legal requirements and the resident’s religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident’s representatives, family, next of kin, and friends.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 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 written policies in relation to the development, use, and review of individual care plans (ICPs), including the Multi-disciplinary Community Individual Care Plan policy and the Multi-disciplinary In-Patient Individual Care Plan policy, which were last reviewed in June 2014 and December 2018 respectively. The policies addressed requirements of the Judgement Support Framework, with the exception of the process and procedure for the required content in the set of documentation making up the individual care plan.

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 not 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 reviewed on inspection. The ICPs were a composite set of documents and included space for goals, treatment, care, and resources required, as well as a section for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address the immediate needs of the resident.

An ICP was developed by the MDT following a comprehensive evidence-based assessment, within seven days of admission. This assessment included: medical, psychiatric and psychosocial history; medication history and current medications; communication abilities; educational, occupation and vocational history; social, interpersonal, and physical environment-related issues, including resilience and strengths; a physical health assessment; and a detailed risk assessment. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the residents and their representatives, family, and next of kin, as appropriate. However, one ICP did not identify a resident’s assessed needs or their appropriate goals.

The ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs identified the resources required to provide care and treatment and a key worker to ensure continuity in the implementation of the residents’ ICPs. The ICPs included an individual risk management plan, although one did not include a preliminary discharge plan, where deemed appropriate. The resident’s ICPs were reviewed by the MDT in
consultation with the residents, weekly in Unit 4 and at least every six months for residents in the continuing care units.

The ICPs were not updated following review, as indicated by the residents’ changing needs, condition, circumstances, and goals. Residents had access to their ICPs; however, four files did not contain evidence that the residents had been offered a copy of their ICP, nor had they recorded if the offered copies were refused by residents and reasons given as to why.

The approved centre was non-compliant with this regulation because one ICP did not identify appropriate goals for the resident.
### Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

| Quality Rating | Satisfactory |

(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 December 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the planning and provision of therapeutic services and programmes within the approved centre.

**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, appropriate and met the assessed needs of the residents, as documented in their individual care plans (ICPs). The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of all therapeutic services and programmes, in the form of a comprehensive timetable, was provided in each unit of the approved centre. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Therapeutic services and programmes were well resourced and provided in a separate dedicated room containing facilities and space for individual and group therapies. However, the designated room for therapeutic services in Unit 4 was also used by the multi-disciplinary team which could cause disruption to activities. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes in residents’ ICPs or 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 training and education pillars.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The file relating to one emergency transfer was examined on inspection. The communication records with the receiving facility were documented, including the agreement of resident receipt prior to transfer. Verbal communication and liaison had taken place between the approved centre and the receiving facility prior to the transfer. This included a discussion of the reasons for the transfer, the resident’s care and treatment plan, which incorporated needs and risks, and the resident’s accompaniment requirements on transfer.

As the resident was unconscious at the time of the assessment and transfer, consent could not be received. An assessment of the resident was completed prior to transfer, including an individual risk assessment relating to the transfer and the resident’s needs. This was documented and provided to the receiving facility. Full and complete written information for the resident was transferred when they were moved from the approved centre to another facility. A transfer form and referral letter accompanied the resident on transfer, to a named individual. The transfer form included a checklist completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. Copies of all records relevant to the resident transfer were retained in the resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 19: General Health

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The policy was last reviewed in December 2018. The policies and procedures included all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: All units of the approved centre had an emergency trolley and staff had access at all times to an AED. These were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Five clinical files were reviewed on inspection. A registered medical practitioner assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with individual care plans (ICPs) and resident’s general health was monitored and assessed as indicated by the residents’ specific needs, but not less than every six months.

The six monthly general health assessments included a physical examination and documented family and personal history, Body Mass Index, weight and waist circumference, as well as smoking and nutritional status, dental health, and medication review. For residents on anti-psychotic medication, there was a documented annual assessment of their glucose regulation, blood lipids, prolactin and an electrocardiogram. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. Residents could access national screening programmes that were available according to age and gender, including breast check, cervical screening, retina check and bowel screening. Information was provided to residents...
regarding the national screening programmes available through the approved centre and residents had access to smoking cessation programmes.

The approved centre was 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 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 December 2018. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre’s information booklet that detailed the care and services in the approved centre. The booklet was available in the required formats to support resident needs and information was clearly and simply written. The information booklet contained housekeeping arrangements, including for personal property and mealtimes, as well as the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents’ rights.

Residents were provided with the details of their multi-disciplinary team and given both written and verbal information on diagnosis, unless the provision of such information was prejudicial to the resident’s physical or mental well-being. Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. The information in the documents provided by or within the approved centre was evidence-based and appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training 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 December 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents were called by their preferred name and the general demeanour of staff and their communication with residents was respectful and conducive to maintain resident privacy and dignity. Staff appearance and dress was also appropriate. Staff were discrete when discussing a resident’s condition or treatment needs and sought permission before entering residents’ rooms. All residents were wearing clothes that respected their privacy and dignity.

Bathrooms, showers and single bedrooms had locks on the inside of the door as appropriate, however not all toilets could be securely locked from the inside. One toilet door was noted to have a lock on both the inside and outside of the door and therefore did not provide suitable privacy. Where residents shared a room, bed screening ensured that their privacy was not compromised. Single room door observation panels in Units 3 and 8 were not suitably screened to protect the privacy and dignity of the resident within the room. Rooms were not overlooked by public areas or, if they were, the windows had opaque glass. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

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

a) Not all toilets could be securely locked from the inside as one toilet’s external handle could override lock function.

b) Single room door observation panels in Units 3 and 8 were not suitably screened to protect the privacy and dignity of the resident within the room.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed 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: Residents had access to personal space and appropriately sized communal rooms were provided. Rooms were ventilated and communal rooms were suitably sized and furnished to remove excessive noise. The lighting in communal rooms suited the needs of residents and staff and it was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Sufficient spaces were not provided for residents to move about, including outdoor spaces. Minimisation of ligature points was not to the lowest practicable level, based on risk assessment.

The approved centre was not kept in a good state of repair externally and internally. There was no documented programme of general or planned maintenance. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. However, responses to maintenance requests were uncertain and poorly communicated, and there was no apparent awareness at local level as to the prioritisation or scheduling of any requested maintenance. There was a cleaning schedule implemented within the approved centre, however, it was
not clean, hygienic or free from offensive odours, as toilets were observed to be dirty and malodourous. There was suitable and sufficient heating, and rooms were centrally heated, with pipe work and radiators appropriately guarded. The heating, however, could not be safely controlled in the residents’ own rooms, in compliance with health and safety guidance and building regulations. Current national infection control guidelines were followed and back-up power was available to the approved centre.

Residents in Unit 8 did not have access to a sufficient number of showers: there was one shower for 18 residents. Toilets were accessible, clearly marked and close to day and dining areas. Wheelchair accessible toilet facilities were identified for use by visitors who required such facilities and there was at least one assisted toilet per floor, as well as appropriately sized lifts, where applicable. The approved centre had a designated sluice room, cleaning room and laundry room. There were dedicated therapy and examination rooms and all resident bedrooms were appropriately sized to address residents’ needs. The approved centre did not provide suitable furnishings to support resident independence and comfort: furnishings in a number of areas were dilapidated and in need of replacement. Assisted devices and equipment were provided to address residents’ needs. Where substantial changes were required to the approved centre premises, this was not appropriately assessed prior to implementation for possible impact on residents and staff. Remote or isolated areas of the approved centre were monitored.

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

a) The approved centre was not maintained in good structural and decorative condition, 22(1)(a).
b) The approved centre was not adequately clean as it was not free from offensive odours, 22(1)(a).
c) A programme of routine maintenance and renewal of the fabric and decoration in the approved centre was not evident, 22(1)(c).
d) The approved centre did not have adequate showers and bathrooms with regard to the number and mix of residents in the approved centre, 22(2).
e) Residents, particularly in Unit 8, did not have access to an outdoor areas, 22(3).
f) Ligature points were not minimised throughout the approved centre, 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 November 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Ten MPARs were reviewed on inspection. The MPARs contained two appropriate resident identifiers and had space for routine medications, once-off medications and “as required” medications. A record of any allergies or sensitivities to any medications and the generic name and preparation of medication, written in full, was also detailed in the MPARs, as was: the frequency of administration of medication, including the minimum dose interval; the administration route for medication; a record of all medications administered to and refused by the resident, and; a clear record of the date of initiation of each medication. The dose to be given was not correctly detailed in one MPAR as an error had been scored out and a correction rewritten, as opposed to a new prescription being written. Micrograms were written in full in all MPARs reviewed. An MPAR did not contain a clear record of the date of discontinuation for each medication.

The Medical Council Registration Number (MCRN) and signature of a medical practitioner was illegible on one prescription within one MPAR. All other entries in the MPARs were legible, and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident’s care or condition: these were documented in the residents’ clinical files. One prescription had not been rewritten following an alteration to the dose. Instead, an incorrect dose had been scored out and a second dose written in. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner.

All medicines were administered in accordance with the directions of the prescriber and any advice provided by the residents’ pharmacist regarding the appropriate use of the product. The expiration date
of medications were checked prior to administration and expired medications were not administered. Where a resident’s medication was withheld or was refused by the resident, this was noted in their MPAR, documented in the clinical file, and, in the case of refusal, communicated to medical staff. Good hand-hygiene techniques were implemented during the dispensing of medications. Schedule 2 controlled drugs were checked by two staff members against the delivery form and details were entered in the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book. At the time of inspection no residents in the approved centre were in receipt of Schedule 2 controlled drugs.

Direction to crush medication was only accepted from the residents’ medical practitioner, a documented reason for doing so was provided, and the pharmacist was consulted about the type and preparation to be used. The crushing of medication was documented in the MPARs. Medication was stored in the appropriate environment as indicated on the label or packaging, or as advised by the pharmacist, and where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were incorporated in the cleaning and housekeeping schedules and were clean and free from damp, mould, litter, dust, pests, and from spillage or breakage. Food and drink was not stored in areas used for the storage of medication. Medication dispensed or supplied to the residents were stored securely in a locked storage unit and the medication trolley remained locked at all times and secured in a locked room. There was a separate cupboard available for Schedule 2 and 3 controlled drugs, though there were no controlled drugs being administered in the approved centre at the time of inspection. A system of stock rotation was implemented, to avoid accumulation of old stock and an inventory of medications was conducted on a monthly basis, which checked the name and dose of medication, the quantity of medication, and the expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

a) In one MPAR reviewed, the prescriber’s signature and MCRN were illegible for a number of prescriptions, 23(1).

b) One MPAR reviewed did not document the discontinuation/stop date for a prescription, 23(1).

c) In one MPAR inspected, a prescription had been altered where an error occurred and not rewritten, 23(1).
### Regulation 24: Health and Safety

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in December 2018. It also had an associated safety statement, dated February 2019. The policy and safety statement addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Infection control measures including:
  - Raising awareness of residents and their visitors to infection control measures.
  - Linen handling.
  - Covering of cuts and abrasions.
  - Management and reporting of an infection outbreak.
  - Support provided to staff following exposure to infectious diseases.
  - First aid response requirements.
  - Vehicle controls.

**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.

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy and procedures did not address the following:

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

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

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

Evidence of Implementation: The numbers and skill mix of staffing were sufficient to meet resident needs. There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. A planned and actual staff rota, showing the...
staff on duty at any one time during the day and night, was maintained in the approved centre. All staff, including permanent, contract and volunteers, were recruited, selected and vetted in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment, and information from referees was sought and documented. Staff had the appropriate qualifications to do their job and an appropriately qualified staff member was on duty and in charge at all times. There was no written staffing plan for the approved centre.

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

Annual staff training plans had not been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Both orientation and induction training was completed for staff. Not all staff were trained in fire safety, Basic Life Support, management of violence and aggression, or the Mental Health Act, 2001. All staff had received training in Children First.

Staff had been trained in manual handling, risk management, incident reporting, and infection control and prevention, including sharps and hand hygiene techniques. However, not all staff had been trained in dementia care, end of life care, resident rights, care for residents with intellectual disabilities, recovery-centred approaches to mental health care and treatment, nor protection of children and vulnerable adults. All staff training was documented and logs were maintained. Opportunities were made available to staff by the approved centre for further education and these were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. A formal in-service training schedule was not implemented within the approved centre, however, facilities and equipment was available for staff in-service education and training. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

<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 (52)</td>
<td>49</td>
<td>94%</td>
<td>45</td>
<td>84%</td>
<td>41</td>
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<td></td>
<td></td>
<td></td>
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<td>78%</td>
</tr>
<tr>
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<td>0%</td>
<td>5</td>
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<tr>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
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<td>66%</td>
<td>4</td>
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<td>Psychologist (6)</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>
The following is a table of clinical staff assigned to the approved centre.

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 2</td>
<td>CNM</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.6 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.4 WTE (shared)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0.5 WTE (shared)</td>
<td></td>
</tr>
</tbody>
</table>

_Social work and Psychology hours shared across all units_

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
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<td>Unit 3</td>
<td>CNM</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.6 WTE (shared)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.4 WTE (shared)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0.5 WTE (shared)</td>
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</tbody>
</table>

_Occupational therapy hours shared between Unit 3 and Unit 8._

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
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<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
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<td></td>
<td>HCA</td>
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<td>0</td>
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<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.8 WTE</td>
<td></td>
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<tr>
<td></td>
<td>Psychologist</td>
<td>0.5 WTE (shared)</td>
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</table>

_Unit 4 access to Social work is via referral to community sector teams_

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
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<td>Unit 8</td>
<td>CNM</td>
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<tr>
<td></td>
<td>RPN</td>
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<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.6 WTE (shared)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.4 WTE (shared)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0.5 WTE (shared)</td>
<td></td>
</tr>
</tbody>
</table>

_Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)_

The approved centre was non-compliant with this regulation because not all staff had up-to-date training in fire safety, Basic Life Support, the management of violence and aggression, and the Mental Health Act, 2001, 26(4).
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 December 2018. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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

Evidence of Implementation: All residents’ records were physically stored together and secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. A record was initiated for every resident assessed or provided with care and services by the approved centre. Resident records were reflective of the residents’ current status and the care and treatment being provided and were maintained using an identifier that was unique to the resident. Resident records were developed and maintained in a logical sequence and were in good order, with no loose pages. Only authorised staff had access to resident records. Entries into resident records were only made by authorised staff. Residents’ access to their records was managed in accordance to the Data Protection Acts.
Records were written legibly in black, indelible ink, were readable when photocopied, and entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Two appropriate resident identifiers were recorded on all documentation and each entry included the date and were followed by a signature; however, all entries did not note the time using the 24-hour clock. Every unit within the approved centre maintained a record of all signatures used in the residents’ records, which was stored in the nurse’s station in each unit. There were no student nurses or clinical training staff in the approved centre at the time of inspection.

Where an error was made, this was scored out with a single line and the correction was written alongside with date, time, and initials. Correction fluid was not used on the approved centre’s records. Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title. Information given over the phone by a member of staff was documented as such by the member of staff who took the call and the person giving the information was clearly identified. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation for food safety and health and safety was maintained within the approved centre. Fire inspection reports for units 2 and 4 were maintained within the approved centre, however, there was no documentation of fire inspections for Unit 8 (Floor 2) and Unit 3. Records were retained or destroyed in accordance with legislative requirements and the policy and procedures of the approved centre.

The approved centre was non-compliant with this regulation because documentation relating to fire inspection for Unit 8 and Unit 3 was not maintained within the approved centre, 27(3).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record a diagnosis on admission or on discharge.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the register of residents included all the required information specified in Schedule 1 to these Regulations, 28(2).
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.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes</strong>: 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 December 2018. It included all of the requirements of the Judgement Support Framework.</td>
</tr>
</tbody>
</table>

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

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

| Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, including services users, as appropriate. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved and communicated to all relevant staff. The format of policies and procedures was standardised and included the title of the policy and procedure, the document approvers, scope of the policy, scheduled review date, and the date at which the policy was implemented. Reference and revision number for the policy and procedure were not included in the standardised format; nor were the document owner, reviewers where applicable, and total number of pages. Generic policies were not used in the approved centre. |

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

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

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

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

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

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

The approved centre was 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 December 2018. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make complaints, including verbally, in writing, electronically by email, on the phone, or through complaint, feedback and suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

Information about the complaints procedure was provided to residents and their representative at admission or soon thereafter. However, the information provided was not up-to-date; the nominated person responsible for complaints had changed in recent months, yet, at the time of the inspection,
information provided to residents in the booklet and on publically displayed notices still detailed the previous person responsible.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. A method for addressing minor complaints within the approved centre was provided and all minor complaints and their outcomes were documented in separate logs for each unit. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s Individual Care Plan (ICP).

Timeframes were provided for responding to complaints following their initial receipt, the investigation period for complaints and their required resolution. Where time frames were not achieved or further investigation time was required in relation to the complaint, this was communicated to the complainant. Complainants were informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them and the complainants’ satisfaction, or dissatisfaction, with the investigation findings were documented. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of relevant data protection acts.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation 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 several of written policies in relation to risk management and incident management procedures. These included: the Risk Management policy, last reviewed in June 2018; the Risk Management – Non-Clinical policy, last reviewed in March 2017, and the Incident Reporting policy, last reviewed in February 2017. The combined policies addressed requirements of the Judgement Support Framework, including the following:

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

The policies did not address the process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre, including:

- Organisational risks.
- Capacity risks relating to the number of residents in the approved centre.
- Health and safety risks to the residents, staff, and visitors.
- Risks to the resident group during the provision of general care and services.
- Risks to individual residents during the delivery of individualised care.

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. Clinical staff were trained in individual risk management processes. Management were not trained in organisational risk management. All staff had
been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. 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. The audit did not measure actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation and the person with responsibility for risk was identified and known by all staff. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Clinical risks and health and safety risks were identified, assessed, treated, reported, monitored, and were documented in the risk register as appropriate. The lack of washing facilities on Unit 8 (Floor 2) and the potential impact on resident hygiene and dignity was a significant unidentified, unassessed and untreated risk within the approved centre. This was not documented in the local risk assessments, local risk register or the area risk register.

Individual risk assessments were completed prior to and during physical restraint, resident transfer, resident discharge, as well as in conjunction with medication requirements or administration and at admission to identify individual risk factors. However, individual risk assessments were not completed prior to mechanical restraint. Multi-disciplinary teams and residents and their representatives were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were not appropriate and implemented as required. While the Health Service Executive policy on safeguarding vulnerable adults from abuse had been adopted by the approved centre, no training in line with the policy had been offered to staff.

Incidents were recorded and risk-rated in a standardised format, though not all clinical incidents were reviewed by the multi-disciplinary team at their regular meetings: only serious incidents were reviewed at the Serious Incident management meeting. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services and the approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided being anonymous at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies which incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because it did not identify and assess the risk in relation to the limited washing facilities on Unit 8, 32(a).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with three conditions to registration attached. The certificate was displayed prominently within the approved centre.

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

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 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: One episode of mechanical restraint was reviewed on inspection. Mechanical restraint to prevent enduring risk of harm to self or others was only used to address an identified clinical need and when less restrictive alternatives were unsuitable. In the episode reviewed, mechanical restraint was not ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf. While the order had not been prescribed by a RMP under the care of a Consultant Psychiatrist, the care around the management of the lap belt was evident.

The clinical file examined did not specify whether there was an enduring risk of harm to self or others, or if less restrictive alternatives were implemented without success. The clinical files did not specify the type of mechanical restraint used, the situation in which the mechanical restraint was being applied, the duration of the restraint, the duration of the order, or the review date.

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

a) Mechanical restraint had not been ordered by a registered medical practitioner, 21.3.
b) The clinical file did not contain a contemporaneous record that specified if there was an enduring risk of harm to self or others, 21.5(a).
c) The clinical file did not contain a contemporaneous record that specified that less restrictive alternatives were implemented without success, 21.5(b).
d) The clinical file did not contain a contemporaneous record that specified the type of mechanical restraint used, 21.5(c).
e) The clinical file did not contain a contemporaneous record that specified the situation in which the mechanical restraint was being applied, 21.5(d).
f) The clinical file did not contain a contemporaneous record that specified the duration of the restraint, 21.5(e).
g) The clinical file did not contain a contemporaneous record that specified the duration of the order, 21.5(f).
h) The clinical file did not contain a contemporaneous record that specified the review date, 21.5(g).

9.0 Inspection Findings – 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 of that medicine shall not be continued unless either—

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence in both cases that the responsible consultant psychiatrist had undertaken a capacity assessment.

In one case the patient had capacity to consent to medication. A detailed consent form outlining the names of the medications prescribed and a detailed discussion with the patient, which encompassed the nature, purpose, and likely effects of the medication, including both potential risks and benefits of the medication, was evidenced.

In one case the patient was unable to consent to the continued receipt of medication and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed. The form contained the name of the medications being prescribed, the nature and purpose of the medication, any views expressed by the patient in regards to the medication and any supports provided to the patient in relation to these discussions. Authorisation by a second consultant psychiatrist was documented as required.
The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: Three cases of physical restraint were reviewed as part of the inspection process. In all cases physical restraint was used in rare, exceptional circumstances, in the best interests of the residents and where the residents posed an immediate threat of serious harm to themselves or others. Physical restraint was based on a risk assessment and only used after all alternative interventions to manage the residents’ unsafe behaviour had been considered. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

In all cases reviewed, physical restraint was initiated by a registered medical practitioner (RMP), a registered nurse, or other member of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated staff member was responsible for leading in the physical restraint of the residents and for monitoring the head and airway of the resident. The consultant psychiatrist or the duty consultant psychiatrist was notified as soon as was practicable and this was recorded in the clinical file. The order for physical restraint lasted for a maximum of 30 minutes and an examination was completed by a RMP no later than three hours after the start of physical restraint. Clinical practice forms were completed in all cases no later than three hours after the episode of physical restraint by the person who had initiated and ordered it, and this was signed by the consultant psychiatrist within 24 hours and placed in the resident’s clinical file.

The residents were informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, unless the information was prejudicial to the residents’ mental health, well-being or emotional condition. As soon as was practicable and with the resident’s consent, their next of kin or representative was informed of the use of physical restraint, with a record of the communication placed in the clinical file. In one episode reviewed a resident had capacity but did not consent to informing next of kin of the physical restraint: this was documented in the clinical file. Staff were aware of relevant considerations in individual care plans pertaining to the residents’ requirements in relation to the use of physical restraint. Special consideration was given when restraining a resident who was known by the staff involved in physical restraint to have experienced physical or sexual abuse.
Where practicable, a same sex staff member was present at all times during all cases of physical restraint reviewed. The residents were afforded the opportunity to discuss the episode with members of their MDTs as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the resident’s clinical files no later than two working days after the episode.

The approved centre was compliant with this code of practice.
INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to admission, transfer, and discharge, and a separate policy relating to discharge against medical advice, which was dated March 2017.

Admission: The admission policy, which was last reviewed in March 2017, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in March 2017, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in March 2017, 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 policy.

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

Evidence of Implementation:

Admission: The approved centre had a key worker system in place. The admission of one resident was examined on inspection and this admission was on the basis of mental illness or mental disorder. An admission assessment had been completed and included: the presenting problem; past psychiatric history, as well as family and medical history; current and historic medication; social and housing circumstances; current mental health state; a risk assessment, and; any other relevant information, such as work situation, education, and dietary requirements. The assessment also included a full physical examination.

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

Discharge: The discharge process pertaining to one resident was examined as part of the inspection. A discharge plan had been completed and included an estimated date of discharge, a follow-up plan, and a reference to early warning signs of relapse and risks; however, the discharge plan did not include documented communication with the relevant general practitioner, primary care team or Community Mental Health Team (CMHT).

Discharge meetings were held and attended by the resident, key worker and relevant members of the resident’s multi-disciplinary team, as well as family, carer or advocate. The discharge assessment addressed the psychiatric and psychosocial needs of the resident, as well as a current mental state examination, a comprehensive risk assessment and risk management plan, social and housing needs, and informational needs.
The discharge was coordinated by the key worker. A preliminary discharge summary was sent to the general practitioner, primary care team or CMHT within three days and a comprehensive discharge summary was issued within 14 days. This included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, and follow-up arrangements. The discharge summary did not include contact details of key people for follow-up or risk issues, such as signs of relapse. Family members, carers and advocates were involved in the discharge process where possible and there was a timely follow-up appointment.

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

a) The discharge plan did not contain documented communication with the relevant general practitioner or primary care team or the Community Mental Health Team, 34.2.

b) The discharge summary did not include contact details of key people for follow-up, 38.4.

c) The discharge summary did not document risk issues, such as signs of relapse, 38.4.
## Regulation 21: Privacy

### Reason ID : 10000700

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Not all toilets could be securely locked from the inside as one toilet's external handle could override lock function.</td>
<td>Complete</td>
<td>Complete</td>
<td>01/01/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>This matter has been addressed across the approved centre</td>
<td>Complete</td>
<td>Complete</td>
<td>01/01/2020</td>
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</table>

### Reason ID : 10000701

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<thead>
<tr>
<th>Specific</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Single room door observation panels in Units 3 and 8 were not suitably screened to protect the privacy and dignity of the resident within the room.</td>
<td>Complete</td>
<td>Complete</td>
<td>01/01/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>This matter has been addressed across the approved centre</td>
<td>Complete</td>
<td>Complete</td>
<td>01/01/2020</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

#### Reason ID: 10000689

**Ligature points were not minimised throughout the approved centre, 22(3).**

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A recent meeting with the fire and safety officer has identified key priorities with the approved centre in terms of managing ligature risk. This has commenced with Unit 4 and will continue throughout the approved centre.</td>
<td>Template developed to monitor ligature actions and remedy of same</td>
<td>13/03/2020</td>
<td>Area Administrator, Maintenance Officer</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ligature points will be minimised where possible with any new works encompassing</td>
<td>Works will be undertaken in accordance with prioritisation and funding</td>
<td>13/03/2020</td>
<td>Local Management Team</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000690

**Residents, particularly in Unit 8, did not have access to an outdoor areas, 22(3).**

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<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Beech Hedging will form an allocated space on the ground floor of unit 8 most adjacent to the lift for the residents of Unit 8 Floor 2.</td>
<td>This CAPA will be completed when the hedging is planted as it will create the defined area</td>
<td>31/03/2020</td>
<td>Area Administrator, Maintenance Officer</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>This defined space will act as a designated outdoor space for the</td>
<td>This space will act as an appropriate area for residents to</td>
<td>31/03/2020</td>
<td>Area Administrator, Maintenance Officer</td>
</tr>
</tbody>
</table>
Residents of Unit 8 Floor 2. access outdoor space.

**Reason ID : 10000691**

The approved centre did not have adequate showers and bathrooms with regard to the number and mix of residents in the approved centre, 22(2).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The tenders for the relevant bathroom works have been received and reviewed. It is anticipated that contracts for same will commence on 15/01/2020. The works in the washroom in Unit 4 are now fully complete and the washroom is functional for residents</td>
<td>In line with the previous correspondence issued to the MHC in relation to this matter that outlined the anticipated schedule for the programme of works, the renovations of the relevant bathroom facilities will address this identified deficit. Completed Washroom facilities reviewed by MHC as part of the pre registration site tour November 2019.</td>
<td>This project is both on schedule at this time. Washroom works are complete</td>
<td>01/05/2020</td>
</tr>
</tbody>
</table>

<p>| <strong>Preventative Action</strong> | The completion of the works will ensure the Approved Centre has adequate and appropriate facilities to meet the needs of residents. | The Approved Centre will have the appropriate facilities to meet the needs of residents | This project is both on schedule at this time. | 01/05/2020 | North Cork Mental Health Services Local Management Team |</p>
<table>
<thead>
<tr>
<th>Reason ID : 10000692</th>
<th>A program of routine maintenance and renewal of the fabric and decoration in the approved centre was not evident, 22 (1)(c).</th>
</tr>
</thead>
</table>
| **Corrective Action** | **Specific** Monthly Walk Through of Units to identify required maintenance have commenced  
|                      | **Measurable** Maintenance walk arounds will occur monthly  
|                      | **Achievable/Realistic** This is both achievable and realistic  
|                      | **Time-bound** 09/01/2020  
|                      | **Post-Holder(s)** North Cork Mental Health Services Local Management Team |
| **Preventative Action** | **Specific** Non standard Work Request maintenance form is now in use to address unplanned maintenance.  
|                      | **Measurable** Quarterly Meeting with Maintenance department to review progress and update on works.  
|                      | **Achievable/Realistic** This is both achievable and realistic  
|                      | **Time-bound** 09/01/2020  
|                      | **Post-Holder(s)** North Cork Mental Health Services Local Management Team |

<table>
<thead>
<tr>
<th>Reason ID : 10000693</th>
<th>The approved centre was not adequately clean as it was not free from offensive odours, 22(1)(a).</th>
</tr>
</thead>
</table>
| **Corrective Action** | **Specific** All areas identified as having offensive odours have been subject to deep cleaning on several occasions since the inspection  
|                      | **Measurable** Deep cleans will continue in these areas as appropriate to reduce the offensive odours.  
|                      | **Achievable/Realistic** This work is ongoing and is achievable and realistic  
|                      | **Time-bound** 01/01/2020  
|                      | **Post-Holder(s)** Domestic Supervisor and relevant staff/contractors |
| **Preventative Action** | **Specific** The Deep Cleans and general cleaning across the approved centre are subject to monitoring and routine audits to ensure effectiveness  
|                      | **Measurable** The audits will provide a measure in relation to cleaning activity in the approved centre  
|                      | **Achievable/Realistic** This is both achievable and realistic  
|                      | **Time-bound** 01/04/2020  
|                      | **Post-Holder(s)** Domestic Supervisor and relevant staff/contractors |

<table>
<thead>
<tr>
<th>Reason ID : 10000694</th>
<th>The approved centre was not maintained in good structural and decorative condition, 22(1)(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
</tbody>
</table>
Corrective Action

The following works have been completed since the last inspection: (1) The completion of the washroom and the redecoration of the entrance and hallway of Unit 4. (2) The installation of the TV unit in the Recreation Room in Unit 4 (3) The replacement of water damaged ceiling tiles in Unit 2 and Unit 4 (4) The renovation of the single bedroom in Unit 2 as well as the repainting of the ceilings in Unit 2. (5) The replacement of fire doors in Unit 2. (6) The repainting of the corridor in Unit 8 Floor 2 as well as the replacement of the lino in the second Day Room on this unit. Both Unit 8 Floor 2 and Unit 4 benefitted

Initial identified items complete but programme of works ongoing.

Routine maintenance works are achievable and realistic and based on identified need.

01/01/2020

Area Administrator, Maintenance Officer
from the purchase of new furniture.

| Preventative Action | Monthly Walk Through of Units to identify required maintenance have commenced | Maintenance Walk Around will occur once per month | This is both achievable and realistic. | 28/02/2020 | North Cork Mental Health Services Local Management Team |
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

| Reason ID : 10000695 | In one MPAR reviewed, the prescriber's signature and MCRN were illegible for a number of prescriptions, 23(1). One MPAR reviewed did not document the discontinuation/stop date for a prescription, 23(1). In one MPAR inspected, a prescription had been altered where an error occurred and not rewritten, 23(1). |

| Corrective Action | The MPAR contains instructions to relevant staff regarding the correct completion of the document. All staff will be reminded of the importance of these instructions. This also forms part of NCHD induction training. | The correct completion of the MPAR is subject to ongoing audit in order to improve compliance. | This is both achievable and realistic as it forms part of the normal duties of relevant staff. | 28/02/2020 | North Cork Mental Health Services Local Management Team |

| Preventative Action | The need to complete the MPAR correctly is emphasised to all relevant staff during induction and as part of training. | The correct completion of the MPAR is subject to ongoing audit in order to improve compliance. | This is both achievable and realistic as it forms part of the normal duties of relevant staff. | 28/02/2020 | North Cork Mental Health Services Local Management Team |
### Regulation 27: Maintenance of Records

**Reason ID: 10000702**

The approved centre was non-compliant with this regulation because documentation relating to fire inspection for Unit 8 and Unit 3 was not maintained within the approved centre, 27(3).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Achieved</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documentation relating to fire inspections for unit 3 and 8 are now maintained within the approved centre</td>
<td>Achieved</td>
<td>Achieved</td>
<td>01/01/2020</td>
<td>North Cork Local Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Achieved</th>
<th>Achieved</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All future documentation relating to fire inspection will be maintained in the approved centre and available for review.</td>
<td>Achieved</td>
<td>Achieved</td>
<td>01/01/2020</td>
<td>North Cork Local Management Team</td>
</tr>
</tbody>
</table>
### Regulation 28: Register of Residents

<table>
<thead>
<tr>
<th>Reason ID: 10000676</th>
<th>The registered proprietor did not ensure that the register of residents included all the required information specified in Schedule 1 to these Regulations, 28(2).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Diagnosis on admission has now been included in the relevant documentation. This change will be commenced by 03/02/2020 when new documentation is received from printer. All Admissions will include a provisional diagnosis on admission. Achievable and Realistic 03/02/2020 Clinical Director, Assistant Director of Nursing &amp; Area Administrator</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The Changes to Admission documentation will reflect the need for relevant medical staff to provide a diagnosis on admission. An Audit on the register of residents will be conducted to ensure the need to have the diagnosis on admission fulfilled. Achievable and Realistic 28/02/2020 Clinical Director, Assistant Director of Nursing &amp; Area Administrator</td>
</tr>
<tr>
<td>Reason ID : 10000688</td>
<td>The approved centre did not identify and assess the risk in relation to the limited washing facilities on Unit 8, 32(a).</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The risk in relation to the limited washing facilities on Unit 8 Floor 2 has now been included in the Risk Register.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The Local Management Team (LMT) will review risks identified as part of MHC inspections for inclusion in the risk register.</td>
</tr>
</tbody>
</table>
### Rules Governing the Use of Mechanical Means of Bodily Restraint

**Reason ID : 10000680**

<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>Mechanical restraint had not been ordered by a registered medical practitioner, 21.3.</td>
<td>achieved</td>
<td>achieved</td>
<td>01/01/2020</td>
<td>North Cork MHS Local Management Team</td>
</tr>
</tbody>
</table>

**Corrective Action**
- Mechanical restraint is currently no longer in use in the approved centre.

**Preventative Action**
- A policy in relation to mechanical means of bodily restraint is currently being developed for the approved centre.
- An audit will measure compliance with this code of practice.

**Reason ID : 10000681**

<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>The clinical file did not contain a contemporaneous record that specified if there was an enduring risk of harm to self or others, 21.5(a). The clinical file did not contain a contemporaneous record that specified that less restrictive alternatives were implemented without success, 21.5(b). The clinical file did not contain a contemporaneous record that specified the type of mechanical restraint used, 21.5(c). The clinical file did not contain a contemporaneous record that specified the situation in which the mechanical restraint was being applied, 21.5(d). The clinical file did not contain a contemporaneous record that specified the duration of the restraint, 21.5(e). The clinical file did not contain a contemporaneous record that specified the duration of the order, 21.5(f). The clinical file did not contain a contemporaneous record that specified the review date, 21.5(g).</td>
<td>achieved</td>
<td>Achievable</td>
<td>31/05/2020</td>
<td>North Cork MHS Local Management Team</td>
</tr>
</tbody>
</table>

**Corrective Action**

- Mechanical restraint is currently no longer in use in the approved centre. The Policy currently being drafted will take into account the specific deficiencies identified.
- Mechanical means of bodily restraint is currently not in use in the approved centre.

**Preventative Action**
- A policy in relation to mechanical means of bodily restraint is currently being developed for the approved centre.
- An audit will measure compliance with this code of practice.
<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>A Policy in relation to Mechanical means of Bodily restraint is currently being developed to meet future needs if required.</th>
<th>Audits</th>
<th>Achievable</th>
<th>27/03/2020</th>
<th>North Cork Local Management Team</th>
</tr>
</thead>
</table>

Preventative Action

A Policy in relation to Mechanical means of Bodily restraint is currently being developed to meet future needs if required.

Audits

Achievable

27/03/2020

North Cork Local Management Team
<table>
<thead>
<tr>
<th>Reason ID : 10000677</th>
<th>The discharge plan did not contain documented communication with the relevant general practitioner or primary care team or the Community Mental Health Team, 34.2.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The local management team have reviewed the discharge checklist, the discharge form and the detail required for the formal discharge letter sent to GP’s, Primary care team or Community Mental Health Team. The full and proper completion of this documentation will address this deficit in keeping with the Policy.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Audits will be completed to ensure compliance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000678</th>
<th>The discharge summary did not include contact details of key people for follow-up, 38.4. The discharge summary did not document risk issues, such as signs of relapse, 38.4.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The local management team have reviewed the discharge checklist, the discharge form and the detail</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Audits will be completed to ensure compliance</td>
</tr>
</tbody>
</table>

**Code of Practice on Admission, Transfer and Discharge to and from an approved centre**
required for the formal discharge letter sent to GP's, Primary care team and the Community Mental Health team. Full and proper completion of these document's will ensure contact details of key people for follow up as well as risk issues are included in the summary.

| Preventative Action | The Audit on the Code of Practice on Admission, Transfer and Discharge to and from an Approved centre will identify deficits and areas for continuous improvement. | Audit findings will be used to rectify and identified deficiencies in relating to compliance | Achievable and Realistic | 29/02/2020 | North Cork Local Management Team |
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.