St. Vincent's Hospital

ID Number: AC0054

2019 Approved Centre Inspection Report (Mental Health Act 2001)

St. Vincent’s Hospital
Richmond Road
Fairview
Dublin 3

Approved Centre Type:
- Acute Adult Mental Health Care
- Continuing Mental Health Care/Long Stay
- Psychiatry of Later Life
- Mental Health Rehabilitation
- Mental Health Care for People with Intellectual Disability

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor:
St. Vincent’s Hospital

Registered Proprietor Nominee:
Ms Caroline Grenham, Chief Executive

Inspection Team:
Susan O’Neill, Lead Inspector
Dr Enda Dooley, MCRN004155
Mary Connellan
Raj Ramasawmy

Inspection Date: 21 - 24 May 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 26 – 29 March 2018

Date of Publication: Monday 06 January 2020

2019 COMPLIANCE RATINGS

REGULATIONS

- Compliant: 24
- Non-compliant: 2

RULES AND PART 4 OF THE MENTAL HEALTH

- Compliant: 1
- Non-compliant: 1

CODES OF PRACTICE

- Compliant: 1
- Non-compliant: 2
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services                                          Dr Susan Finnerty

In brief

St. Vincent’s Hospital was a public voluntary hospital in Fairview, Dublin. The main building, a former convent, dated from 1899 and various extensions had been added throughout the twentieth century. The approved centre had three units: St. Louise’s ward, a 30-bed admission unit serving the north city area from Clontarf to Ballymun, a 6-bed Psychiatry of Old Age (POA) admission unit, and St. Mary’s ward, a 9-bed continuing care facility. Six consultant-led community teams and a POA team admitted to the hospital.

St. Vincent’s Hospital has shown a steady increase in compliance over the past three years: 62% compliance in 2017; 76% compliance in 2018; and 80% compliance in 2019. Eleven compliances with regulations were rated excellent, compared with two in 2018.

Conditions to registration

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

Condition 1: To ensure adherence to Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines, the approved centre shall audit their Medication Prescription and Administration Records (MPARs) on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre not in breach of Condition 1. The approved centre was non-compliant with Regulation 23: Ordering, Prescribing, Storage and Administration of Medication at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed and food temperatures were recorded in line with food safety recommendations. Catering areas, associated catering, and food safety equipment were appropriately cleaned.
- There was an improvement in the level of mandatory training for staff.
However:

- Two areas outside of the approved centre contained old equipment which was potentially hazardous. The approved centre addressed this issue at the time of the inspection by putting the equipment into a skip. There was a loose stone slab on the grass area outside of the approved centre.
- Numerous potential ligature points were observed throughout the approved centre. Continuous works were underway to minimise these; however, at the time of the inspection, ligature points had not been minimised.
- The approved centre had a designated sluice room in the Psychiatry of Old Age ward but not in St. Mary’s ward or St. Louise’s ward.

Appropriate care and treatment of residents

- Therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents.
- Clinical files were in good condition and securely stored.

However:

- The approved centre was not compliant with Regulation 15: Individual Care Plan. This was the third successive year that the approved centre had been non-compliant with this regulation.
- Residents’ general health needs were not monitored and assessed at least every six months in two out of five clinical files inspected. Residents’ Body Mass Index (BMI), weight and waist circumference were not checked and recorded in four cases. Family and personal history were not recorded in four cases. Smoking and nutritional status was not documented in one case. Dental health reviews were documented in all cases; however, there was no follow up action for one resident.
- Staff were not trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff were not trained in dementia care, end of life care, resident rights, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults.

Respect for residents’ privacy, dignity and autonomy

- A separate visiting area was provided where residents could meet visitors in private in St. Louise’s ward and in the Psychiatry of Old Age ward. There was no dedicated visiting room in St. Mary’s Ward but there were appropriate visiting areas.
- Residents could use mail, fax, their own mobile phones, and a landline telephone if they wished. Supervised computer facilities were available in the activity area. Wi-Fi was not available in the approved centre.
• When searches were carried out, the resident’s consent was sought and documented, the resident was informed by those implementing the search of what was happening during a search and why, and there was a minimum of two clinical staff in attendance at all times when the search was being conducted. Searches were carried with due regard to the resident’s dignity, privacy and gender.

• All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors. Observation panels on the doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Where residents shared a room, the bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information.

• The approved centre was clean throughout.

• The approved centre was compliant with the Rules Governing the Use of Seclusion and Mechanical Restraint (Part 5), Part 4 of the Mental Health Act Consent to Treatment, and with the Code of Practice on Physical Restraint.

However:

• Rooms were not ventilated and two bathrooms were malodourous at the time of the inspection, one of which had a recently installed extractor fan.

• The approved centre was not kept in a good state of repair inside and out. There was no programme of decorative maintenance, and any decorative work was reactionary to faults and issued raised. There were no dedicated therapy or examination rooms.

**Responsiveness to residents’ needs**

• Residents were provided with a variety of wholesome and nutritious food, and had at least two choices of meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

• Residents were provided with locked safes to guard their own property. Where any valuables were taken while in care, access to such was signed for by both the staff and resident.

• The approved centre provided access to recreational activities which included table tennis, board games, indoor exercise with gym machines, word wheel, arts and crafts, as well as outdoor activities such as gardening and outdoor gym machines. Additionally, on St. Mary’s ward, the approved centre provided newspapers, bingo, and music and beauty therapy. In relation to the Psychiatry of Old Age Ward, walks, music, knitting and newspapers were provided.

• There was a chaplain available on site. A spirituality group ran once a week, with emphasis on prayers and meditation. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

However:
• Appropriate signage and sensory aids were not provided to support residents’ orientation needs, with a number of rooms incorrectly signposted. The pharmacy dispensing room of St. Louise’s ward was incorrectly signposted with the title ‘Kitchenette’.

**Governance of the approved centre**

• The approved centre provided services for the HSE through a service level agreement under Section 38 of the Health Act 2004. The approved centre was under the overall governance of a Board of Governors who met every two months. The Clinical Audit committee and the Quality and Safety committee met on a monthly basis and provided regular reports to the Board of Governors. In turn, a number of subcommittees, including Health and Safety, Drugs and Therapeutics, Policy, and Infection Control, informed these committees.

• A Heads of Department meeting took place once a month. The catchment area consultants had joint contracts with the HSE and St. Vincent’s Hospital. All nursing and health and social care personnel were employed directly by St. Vincent’s Hospital.

• There were defined risk management processes throughout the approved centre. A risk register was maintained and this was reviewed on a regular basis at the Executive Management Team meeting; however, the register was not formally monitored through an audit process. The risk register documented several categories of risk, including financial, staffing, organisational and clinical risk. Issues pertaining to risk and incident management were communicated to the wider multi-disciplinary team (MDT) at the monthly Heads of Department meetings.

• The MDT undertook a comprehensive cycle of audit, using specialist audit software. The majority of audits were accompanied by detailed analytical reports and action plans. Audit results were reviewed by the senior management team at the monthly Audit Committee meetings and feedback relating to audit performance was communicated to all disciplines at the Heads of Department meetings.

However:

• The senior management team, comprising the Chief Executive, Clinical Director, and Director of Nursing, were the only members of the Executive Management Team meeting. Other heads of discipline or service user representatives were not part of the senior management team.

• At the time of inspection, there was no social worker present on the team for six weeks. Recruitment of a locum social worker was unsuccessful and emergency cover from disciplines within the admitting community teams was unavailable. Health and social care professionals within these community teams were under HSE management and were only permitted to attend the approved centre for the purposes of pre-discharge planning. This governance arrangement led to a lack of essential social work services for residents in the approved centre.

• A significant organisational risk cited by the approved centre within the risk register was the lack of adherence to governance and reporting relationships in the hospital by some unidentified parties. This could occur when persons with no contractual accountability to St. Vincent’s Hospital engaged outside of the agreed governance structure.
• Training records indicated that not all staff were up-to-date with the required mandatory training, although this had improved compared to previous inspection findings. Specifically, there was a low level of training compliance amongst non-consultant hospital doctors (NCHDs) in relation to Basic Life Support training, as well as Professional Management of Aggression and Violence (PMAV) training.

• At the time of inspection, the peer advocate no longer visited the approved centre, and there had been no representation at the Head of Department meetings for over four months.
The following quality initiatives were identified on this inspection:

1. Introduction of updated forms and documents including the individual care plan, the six monthly general health assessment form and transfer forms.

2. Introduction of a new proforma booklet for the purposes of documenting individual seclusion episodes.

3. Establishment of a Therapeutic Services and Recreational Activities committee for St Mary’s and Psychiatry of Old Age units.

4. Development of two new resident information booklets detailing information on different community resources for residents and health and social care professionals.

5. Implementation of a creative writing project for residents by the Psychology department.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Vincent’s Hospital was a public voluntary hospital located on Convent Avenue in Fairview, Dublin. The main building, a former convent, dated from 1899 and various extensions had been added throughout the twentieth century. The hospital was set within expansive greenery and open space. The approved centre comprised St. Louise’s ward, a 30-bed admission unit serving the north city area from Clontarf to Ballymun, and a 6-bed Psychiatry of Old Age (POA) admission unit. These facilities dated from 1993 and were physically separate from the original building. St. Mary’s ward was a 9-bed continuing care facility located on the first floor of the original building.

Six consultant-led community teams oversaw admissions to the hospital. In addition, a separate POA team oversaw admissions to the POA unit. All residents remained under the care of their respective community teams while in the approved centre.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>45</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>41</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>12</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>3</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>12</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre provided services through a service level agreement under Section 38 of the Health Act 2004. The approved centre was under the overall governance of a Board of Governors who met every two months. The Clinical Audit committee and the Quality and Safety committee met on a monthly basis and provided regular reports to the Board of Governors. In turn, a number of subcommittees, including Health and Safety, Drugs and Therapeutics, Policy, and Infection Control, informed these committees. The senior management team comprised the Chief Executive, Clinical Director, and Director of Nursing who met on a weekly basis at the Executive Management Team meeting. A Heads of Department meeting took place once a month.

The catchment area consultants had joint contracts with the HSE and St. Vincent’s Hospital. All nursing and health and social care personnel were employed directly by St. Vincent’s Hospital. Within the approved centre, the multi-disciplinary team (MDT) was comprised of the core mental health disciplines; however, at the time of inspection, there was no social worker present on the team for six weeks. Funding for a locum
social worker was approved; however, recruitment was unsuccessful (emergency cover from disciplines within the admitting community teams was also unavailable). Health and social care professionals within these community teams were under HSE management and were only permitted to attend the approved centre for the purposes of pre-discharge planning. Service managers acknowledged that short-term staff replacement was challenging for the service.

There were defined risk management processes throughout the approved centre. A risk register was maintained and this was reviewed on a regular basis at the Executive Management Team meeting; however, the register was not formally monitored through an audit process. The risk register documented several categories of risk, including financial, staffing, organisational and clinical risk. A significant organisational risk cited by the approved centre within the risk register was the lack of adherence to governance and reporting relationships in the hospital by some parties. This could occur when persons with no contractual accountability to St. Vincent’s Hospital engaged outside of the agreed governance structure. Issues pertaining to risk and incident management were communicated to the wider MDT at the monthly Heads of Department meetings.

Training records indicated that not all staff were up-to-date with the required mandatory training, although this had improved compared to previous inspection findings. Specifically, there was a low level of training compliance amongst non-consultant hospital doctors (NCHDs) in relation to Basic Life Support training, as well as Professional Management of Aggression and Violence (PMAV) training. Hospital management acknowledged this and reported that, due to the frequency of medical rotations, it was difficult to ensure that all medical staff were fully trained at all times. Training plans for staff were in place and issues relating to staff training requirements and training scheduling were reviewed at the Executive Management Team meeting and at the Quality and Safety committee meeting.

Residents had access to advocacy services via the Irish Advocacy Network. Notices displaying a named advocate and contact details were present in the approved centre and this representative usually attended the monthly Heads of Department meeting. However, at the time of inspection, this advocate no longer visited the approved centre, thus, there had been no representation at the Head of Department meetings for over four months. The hospital manager was in the process of arranging a replacement advocate for the service. 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 involvement in the process of quality improvement. Resident feedback was reviewed at the Heads of Department meetings.

The MDT undertook a comprehensive cycle of audit, using specialist audit software. The majority of audits were accompanied by detailed analytical reports and action plans. Audit results were reviewed by the senior management team at the monthly Audit Committee meetings and feedback relating to audit performance was communicated to all disciplines at the Heads of Department meetings.

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X  Moderate</td>
<td>X  Moderate</td>
<td>X  High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓  ✓</td>
<td>✓  ✓</td>
<td></td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X  Low</td>
<td>X  High</td>
<td>X  High</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X  High</td>
<td>X  Moderate</td>
<td>X  Low</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X  High</td>
<td>X  High</td>
<td>X  Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission of Children</td>
<td>X  High</td>
<td>Not applicable</td>
<td>X  Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X  Low</td>
<td>X  High</td>
<td>X  Low</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance “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 7: Clothing</td>
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<td>Regulation 9: Recreational Activities</td>
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<td>Regulation 10: Religion</td>
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<td>Regulation 11: Visits</td>
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<tr>
<td>Regulation 12: Communication</td>
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<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
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<tr>
<td>Regulation 18: Transfer of Residents</td>
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<tr>
<td>Regulation 20: Provision of Information to Residents</td>
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<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
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<tr>
<td>Regulation 30: Mental Health Tribunals</td>
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</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 no child with educational needs had been admitted to the approved centre since the last inspection, 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>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

The inspection team met with eight residents in total. Residents were complimentary toward both the staff and the service. The majority of residents were satisfied with the facilities, food and activities programme. Two residents reported that they were unable to effectively use their personal safe facility due to physical disability. Safes were located on a low shelf within the wardrobe and those residents found it difficult to bend down to access the safe.

Six resident questionnaires were completed and the following themes were reported:

- The majority of residents had an understanding of their individual care plan; however, two residents reported that they were not always involved in the goal setting process.
- The majority of residents were familiar with the multi-disciplinary team and their key worker.
- Three residents reported that they were not always able to discuss worries or concerns with a member of staff.
- Two residents reported that there were not enough activities to do during the day.
- The majority of residents reported that they had adequate space for privacy and felt respected by staff.
- Four of the residents reported that they did not always feel safe within the approved centre.
- Two residents reported that they did not always feel able to give feedback or make complaints when dissatisfied.
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:

- Chief Executive Officer
- Clinical Director
- Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 1
- Senior Psychologist
- Senior Dietitian
- Senior Occupational Therapist
- Senior Physiotherapist
- Chaplain
- Healthcare Records Manager
- Four Consultant Psychiatrists
- Nursing Practice Development Coordinator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications that they deemed appropriate. The approved centre management reported that plans to improve the visiting room facilities for children had been approved. Also under review were alternative strategies for improving hygiene and ventilation in some of the toilets.
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 May 2019. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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: Three resident identifiers were used, including photograph, name, and date of birth, all of which were appropriate to the resident group profile. The preferred identifiers used for each resident were detailed within residents’ clinical files. Identifiers were person-specific, and did not include room number or physical location. Identifiers were appropriate to residents’ communication abilities. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or a similar name.

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

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

#### INSPECTION FINDINGS

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

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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:** Approved centre menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food, and had at least two choices of meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition.

Hot and cold drinks were offered to residents regularly, and a source of safe, fresh drinking water was available to residents at all times in easily accessible locations throughout the approved centre. Hot meals were also provided on a daily basis. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Some residents in the approved centre required a puree-based diet, which was duly accommodated.

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 did not have a written policy in relation to food safety.

Training and Education: There was no policy for staff to read, understand, or articulate. All staff responsible for handling food had up-to-date training in food safety, commensurate with their role. This training was documented, and evidence of certification was available.

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

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. Appropriate protective equipment, including Personal Protective Equipment (PPE), where required, was used during the catering process. There was suitable and sufficient catering equipment, and there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas, associated catering, and food safety equipment were appropriately cleaned. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Additionally, residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not have a policy in relation to food safety.
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 March 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 monitored on an ongoing basis. This was documented.

Evidence of Implementation: On inspection, all residents were observed to be wearing appropriate personal clothing. Residents’ clothing was clean and appropriate to their needs. An emergency supply of clothing was maintained which was appropriate to resident needs. Residents changed out of nightclothes during daytime hours unless otherwise specified in their individual care plans. Residents also had an adequate supply of individualised clothing.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Residents were provided with locked safes to guard their own property, and they were also encouraged to send such property home or to the main hospital office. All new admissions had a property checklist created as part of the admissions process. This checklist was updated on an ongoing basis, in line with the approved centre’s policy. Residents were encouraged to manage their own monies and valuables. Where any valuables were taken while in care, access to such was signed for by both the staff and resident. Residents were actively encouraged to be responsible for their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: On St. Louise’s ward, the approved centre provided access to recreational activities appropriate to the resident group profile, including the following: table tennis, board games, indoor exercise with gym machines, word wheel, arts and crafts, as well as outdoor activities such as gardening and outdoor gym machines. Additionally, on St. Mary’s ward, the approved centre provided newspapers, bingo, and music and beauty therapy. In relation to the Psychiatry of Old Age Ward, walks, music, knitting and newspapers were provided, ensuring that such recreational activities were appropriate to the resident group profile. At the weekends, if sufficient staff were available, residents could be accompanied to the activity room for book reading, DVDs, and board games.

Information was provided to residents in an accessible format, as current activity timetables were on display boards around both units. Such information included the type and frequency recreational activities available through a four-weekly cycle activity programme sheet. All areas of the approved centre were adequately resourced for the provision of recreational activities. A garden with two items of outdoor gym equipment, which residents could access under the supervision of appropriate staff, provided outdoor exercise and physical activity.

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 January 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 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.

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre and there was an on-site Church available to support residents’ religious practices. Mass was delivered to residents who wished to attend every Wednesday. A chaplain offered communion to residents who were unable to attend Mass. Residents had access to multi-faith chaplains, if required. There was an on-site chaplain on site who worked 09:00 – 17:00, Monday to Friday and was available by bleep. A spirituality group ran once a week, with emphasis on prayers and meditation. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to visits. The policy was last reviewed in April 2019. The policy included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** At the time of the inspection, none of the residents in either of the three wards had restrictions on their rights to receive visitors. Analysis was completed to identify opportunities to improve visiting processes.

**Evidence of Implementation:** Appropriate and reasonable visiting times were publicly displayed at the hospital entrance in each ward of the approved centre. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others, or a health and safety risk. There was a designated visitor’s room in the main reception area of St. Louise’s Ward. There was a meeting room in the Psychiatry of Old Age Ward where private visits could take place. The communal sitting room and the residents’ bedrooms were used the most for visiting purposes. There was no dedicated visiting room in St. Mary’s Ward but there were appropriate visiting areas.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Suitable visitor identification processes were in place for mental health professional visitors, legal representatives and non-clinical visitors. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting areas available were suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: At the time of the inspection, there was no resident with specific harmful communication risks and, as such, their communications were not deemed necessary to be subjected to examination by senior staff. Residents could use mail, fax, their own mobile phones, and a landline telephone if they wished. Supervised computer facilities were available in the activity area. Wi-Fi was not available in the approved centre.

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 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 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 in relation to the implementation of resident searches. The policy was last reviewed in March 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: A log of searches was maintained. Each search record was not systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had been completed to identify opportunities for improvement of search processes.

Evidence Of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file of one resident who was searched was inspected. Risk had been assessed prior to the search of the resident. The resident’s consent was sought and documented.

The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being
conducted. The search was implemented with due regard to the resident’s dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two separate written operational policies, one in relation to care of the dying and the other in relation to the management of the sudden death of a resident. Both policies were last reviewed in March 2018. The policies combined 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 policies. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policies.

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The ICPs of ten residents were inspected. Each ICP was a composite set of documents stored in the clinical file. Each resident was assessed at admission, and an initial care plan was completed by the admitting clinician to address the immediate needs of the resident. In three ICPs inspected, there was no evidence that the ICPs had been prepared and developed within seven days of admission. A specific key worker was not identified in the ten ICPs inspected to ensure continuity in the implementation of residents’ ICPs.

One ICP inspected did not contain specific, accurate, and appropriately defined goals for the residents. Two ICPs did not identify the interventions required to meet the goals identified. Two ICPs did not identify the resources required to provide the care and treatment identified. Six ICPs were not consistently reviewed by the MDT in consultation with the resident on a weekly basis.

Resident involvement in ICPs inspected was not consistently documented, and there was no associated explanation documented for those that were not involved. The ten ICPs inspected included an individual risk management plan and an individual discharge plan.

Not all residents had access to their ICPs and not all residents were kept informed of any changes. Documentation did not adequately show whether residents were given a copy of their ICP, and in three ICPs inspected there was no reason documented as to why a copy was not given to the resident. Where a resident declined or refused a copy of their ICP, the reason for refusal was not consistently documented.

The approved centre was non-compliant with this regulation for the following reasons:
a) Three ICPs inspected were not developed by the MDT in a timely manner, within seven days of admission.
b) ICPs were not reviewed and updated by the resident’s MDT in all cases.
c) One ICP inspected did not contain specific, accurate, and appropriate goals for the residents.
d) Two ICPs inspected did not clearly specify resources required to care and treat for the resident.
e) Documentation did not adequately indicate whether residents were given a copy of their ICP, and in three of the ICPs inspected, there was no reason documented as to why a copy was not given to the resident.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents. This list comprised a four-week schedule, and was followed by a new list of activities for the next four-week cycle was provided. All therapeutic programmes and services were aimed at restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Adequate resources and facilities were available. Therapeutic services and programmes were provided in separate dedicated rooms, and St. Louise’s Ward had facilities to carry out group programmes or one-to-one sessions. All therapeutic services and programmes needed were provided internally. A record was maintained within residents’ clinical files of their participation and outcomes achieved in therapeutic services or programmes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written operational polices, both last reviewed in February 2019. One policy was in relation to the transfer of an involuntary patient and the second policy was in relation to the transfer of a voluntary resident. The policies combined addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: Each transfer record was systematically reviewed to ensure that all relevant information was provided to the receiving facility. A documented analysis was completed to identify opportunities to improve transfer processes. A log of transfers was maintained.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre in an emergency was inspected. Documented consent of the resident to transfer was available. The resident was risk assessed prior to transfer. All relevant information regarding the resident transferred was provided to the receiving facility. Communication between the approved centre and the receiving facility was documented and followed up with a written referral.

The clinical file recorded the documentation sent to the receiving facility as part of the transfer. A copy of this documentation was retained in the resident’s clinical file. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in April 2019. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policy.

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

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator. Emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and whenever indicated by the residents’ specific needs.

Five clinical files were inspected. All residents received a general health assessment; however, only three residents general health needs were monitored and assessed at least every six months. Residents’ Body Mass Index, weight and waist circumference was not checked and recorded in four cases. Family or personal history was not recorded in four cases. Smoking and nutritional status was not documented in one case. Dental health reviews were documented in all cases; however, there was no follow up action for one resident.

Residents on antipsychotic medication received the appropriate annual tests, unless they refused to give consent. Tests included an assessment of their fasting glucose, blood lipids, an electrocardiogram heart function assessment, and their prolactin levels.

Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available, demonstrating residents’ completed general
health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes appropriate to their age and gender.

Information was provided to all residents regarding the national screening programmes available. Residents had access to comprehensive smoking-cessation programmes and supports.

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

a) Two residents’ general health needs were not assessed as required within six months, 19(1)(b).
b) The general health assessments were not adequately completed, as not all included BMI, weight, and waist circumference, 19 (1)(b).
c) The approved centre did not ensure access to dental services as required, 19(1)(a).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents, which was last reviewed in May 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident’s diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents’ 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. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident privacy, which was last reviewed in May 2019. The policy addressed all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policies were 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 addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were discreet when discussing residents’ conditions or treatment needs. Residents wore clothing that respected their privacy and dignity.

Staff were groomed and dressed well, but it was not easy to identify staff from residents and members of the public. Some staff wore uniforms and other staff did not; the female staff in St. Louise’s Ward wore uniforms but the staff in St. Mary’s Ward and the Psychiatry of Old Age Ward did not.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors, unless there was an identified risk to residents’ safety. Observation panels on the doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas.

Where residents shared a room, the bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls, either using their own mobile phones or by using the phone booth 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 monitoring, and evidence of implementation pillars.
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 May 2019. The policy addressed all of the requirements of the Judgement Support Framework.

Training and Education: All 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 separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit and heated, but heating could not be safely controlled from the resident’s own room. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. All resident bedrooms were appropriately sized to address residents’ needs. There was sufficient space for residents to move about, including outdoor spaces. There was a sufficient number of toilets and showers for residents in the approved centre. Remote or isolated areas of the approved centre were monitored.

Hazards were not minimised. Two areas outside of the approved centre contained old equipment which was potentially hazardous. The approved centre addressed this issue at the time of the inspection by putting the equipment into a skip. There was a loose stone slab on the grass area outside of the approved centre.

Numerous potential ligature points were observed throughout the approved centre; continuous works were underway to minimise these but at the time of the inspection, ligature points had not been minimised. The windows in St. Louise’s Ward were due to be replaced in June 2019; funding had been secured.
The approved centre was clean and hygienic. Rooms were not ventilated and two bathrooms were malodourous at the time of the inspection, one of which had a recently installed extractor fan. Appropriate signage and sensory aids were not provided to support residents’ orientation needs, with a number of rooms incorrectly signposted. The pharmacy dispensing room of St. Louise’s Ward was incorrectly signposted with the title ‘Kitchenette’.

The approved centre was not kept in a good state of repair inside and out. The building was over 200 years old, and a number of non-clinical areas were in a poor state of repair at the time of the inspection. There was no programme of decorative maintenance, and any decorative work was reactionary to faults and issued raised. The approved centre had a designated sluice room in the Psychiatry of Old Age Ward but not in St. Mary’s Ward or St. Louise’s Ward. There were no dedicated therapy or examination rooms. The approved centre provided suitable furnishings to support resident independence and comfort.

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

a) The premises were not maintained in good decorative and structural condition, 22(1)(a).

b) There was no programme of decorative maintenance, and any decorative work was reactionary to faults and issued raised, 22(1)(c).

c) The premises were not adequately ventilated; two bathrooms were malodourous, 22(1)(b).

d) The approved centre was not developed and maintained with due regard to the specific needs of residents and patients, and the safety and well-being of residents and patients. This was evidenced by the presence of numerous ligature points, 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 operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in February 2018, and included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of two resident identifiers, records of all medications administered, details of dosage, and the frequency of medication. The Medical Council Registration Number (MCRN) of the medical practitioner prescribing medication to the resident was documented.

Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the resident’s care or condition. This was documented in the clinical file. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration, and expired medications were not administered. All medicines were administered by a registered nurse or a registered medical practitioner, and any advice provided by the resident’s pharmacist regarding the appropriate use of the product was adhered to.

Two MPARs did not record the stop date for each medication. In all ten MPARs inspected, a record of all medications to the resident had been maintained. The ten MPARs inspected recorded residents’ allergy status. The generic name of the medication, and its preparation, were recorded on all MPARs. The signature of the medical practitioner or nurse prescriber for each entry was recorded on all MPARs.

The medication trollies and medication administration cupboards remained locked at all times and were secured in a locked room. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Refrigerators used for medication were not used only for this purpose; drinks were stored in areas used for the storage of medication.
A log was maintained of the refrigeration storage unit temperatures. An inventory of medications was conducted on a monthly basis checking the name and dose of medication, quantity of medication, and expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was non-compliant with this regulation because they did not have appropriate practices in relation to the prescription of medications; two MPARs did not record the stop date for each medication, 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 three written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in March 2018. The policy addressed all the requirements of the Judgement Support Framework.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff. The policy was last reviewed in March 2018, and included the requirements of the Judgement Support Framework, with the exceptions of staff performance and evaluation requirements, and 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 reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify leadership structures and the lines of authority and accountability of the approved centre staff. Staff were recruited in accordance with the approved centre’s policy and procedures for recruitment, selection and appointment.

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. At the time of inspection, residents did not have access to a social worker for a period of approximately six weeks. Funding for a locum social worker was approved; however, recruitment was unsuccessful. The approved centre did not have a staffing plan in place. There was an appropriately qualified staff member on duty at all times. The required number of staff on night duty was sufficient to ensure the safety of residents in the event of a fire or other emergency. Annual staff training plans were completed for staff in order to identify required training and skills development. Orientation and induction training was completed for staff.

Not all health care professionals had up-to-date training in fire safety, Basic Life Support, Management of violence and aggression, The Mental Health Act and Children First, as set out in the table below:
Staff were not trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff were not trained in dementia care, end of life care, resident rights, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults. All staff training was documented.

The Mental Health Act (2001), the associated regulations (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.

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

a) Not all staff were up-to-date with training and education to enable them to provide care and treatment in accordance with best contemporary practice. Not all staff were trained in fire safety, Basic Life Support or Therapeutic Management of Aggression and Violence, 26 (4).

b) At the time of inspection, the approved centre did not have access to a social worker, 26(2).

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry of Old Age</td>
<td>CNM2</td>
<td>1</td>
<td>-</td>
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<tr>
<td></td>
<td>RPN</td>
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</tbody>
</table>

Access to Health and Social Care services is on referral basis only.

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), OT (Occupational Therapist)*
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 two written policies and procedures in relation to the maintenance of records, which were last reviewed in February 2018 and March 2018 respectively. The policies combined addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence Of Implementation: All residents’ records inspected were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. On inspection, a number of clinical files were overfilled. Residents’ records were reflective of their current status, and of the care and treatment being provided. Residents’ records were physically stored together, where possible. Records were developed and maintained in a logical sequence, multiple volumes were numbered to identify a sequence. All resident records inspected were maintained using an identifier that was unique to that resident; and there were two appropriate resident identifiers recorded on all documentation.

Only authorised staff made entries in residents’ records. Records were legible and written in indelible black ink, and were readable when photocopied. Entries in residents’ records were factual, consistent, and accurate. Records were appropriately secured throughout the approved centre from loss, destruction, tampering, and unauthorised access or use.

Records were retained and destroyed in accordance with legislative requirements, and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in January 2019. It included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 30: Mental Health Tribunals

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in February 2018. The policy and procedures included all 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 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 Tribunals process. A dedicated tribunal room was available. Staff accompanied and assisted patients to attend their Mental Health Tribunal and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
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 in place, dated January 2018, in relation to the approved centre’s complaints procedures. The policy included all of the requirements of the Judgement Support Framework. The process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, the approved centre, was detailed in the policy.

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

Monitoring: There was no documented evidence that audits of the complaints log were completed. Complaints data had not been analysed for the purpose of identifying and implementing required actions 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 in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure and nominated person’s contact details were well publicised and accessible to residents, their representatives, and families in the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s ICP. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected because of the complaint being made.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education, and monitoring pillars.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies in relation to risk management and incident management procedures. The risk management policy was last reviewed in March 2018. The policies combined addressed the requirements of the Judgement Support Framework.

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

Monitoring: The risk register was reviewed at least four times a year to determine compliance with the approved centre’s risk management policy. The audit did not measure actions taken to address risks identified against the timeframes identified in the register, as there were no timeframes documented in the risk register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff. Responsibilities were allocated at management level, and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and seclusion, mechanical restraint, and at resident admission and transfer. These assessments
were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained but were effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. Trends of clinical incidents were brought to the attention of the MDT within the Heads of Discipline meetings. If an incident related to a particular discipline this was raised with the relevant person. Not all incidents were reviewed individually at the MDT meeting. There was no record maintained of multi-disciplinary reviews, or of recommended actions.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. The information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was 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, monitoring, and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently in 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 Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) “A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section “patient” includes –
   (a) a child in respect of whom an order under section 25 is in force, and
   (b) a voluntary patient.

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The policy was last reviewed in November 2018 and included all of the relevant guidance criteria of this rule, pursuant to Section 69 of the Mental Health Act 2001, which included:

- Who may implement seclusion.
- The provision of information to the resident.
- Ways of reducing seclusion use.

Training and Education: The approved centre maintained a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy.

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

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or a registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

The clinical files of three residents who had each been in seclusion on one occasion were inspected. The approved centre complied fully with the code of practice on the use of seclusion across the three episodes. In all episodes inspected, seclusion was only implemented in the resident’s best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to themselves or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion on all occasions.
Each episode of seclusion was reviewed by members of the multi-disciplinary team and was documented in the resident’s clinical file within two working days after the episode of seclusion. All episodes of seclusion were recorded in the resident’s clinical file and all uses of seclusion were recorded in the seclusion register. A copy of the seclusion register was in place within the resident’s clinical file and was readily available to inspectors.

The approved centre was compliant with this rule.
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

The clinical file of one resident who had been mechanically restrained was inspected. The approved centre complied with Part 5 of the Rules Governing the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others.

Mechanical restraint was only practiced when the resident posed an enduring risk of harm to themselves or to others, or to address a clinical need, and was only used when less restrictive alternatives were not suitable. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the resident, or by the duty consultant psychiatrist acting on his/her behalf.

The clinical file contained a contemporaneous record that specified the following:

- That there was an enduring risk of harm to self or to others.
- That less restrictive alternatives were implemented without success.
- The type of mechanical restraint.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The approved centre was compliant with this rule.
9.0 Inspection Findings – Mental Health Act 2001

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

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

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

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

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

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

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

INSPECTION FINDINGS

The clinical 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. In both cases, there was documented evidence that the consultant psychiatrist had undertaken a capacity assessment, which measured the patients’ ability to consent to receiving treatment. Following the capacity assessment, both patients were deemed unable to consent to receiving treatment.

In relation to both of these patients who were unable to consent to treatment, a Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been appropriately completed for each patient. The form evidenced the following:

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

Any views expressed by the patient were documented for one patient on the associated Form 17. Any views expressed by the second patient were not documented on the associated Form 17; this was not possible due to the nature of the patient’s condition.

All forms were completed within the appropriate timeframe.

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

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

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

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

COMPLIANT

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in November 2018. The policy met the complete policy guidance criteria of this code of practice.

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

Monitoring: The approved centre forwarded the relevant annual report to the MHC.

Evidence of Implementation: The files of three residents who had been physically restrained were reviewed. Physical restraint was only used in rare and exceptional circumstances, when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident’s unsafe behaviour. In all cases, the restraint order lasted for less than 30 minutes.

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

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

The approved centre was compliant with this code.
Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had policies, last reviewed in May 2019, and procedures in place in relation to the admission of a child. The approved centre had a policy requiring each child to be individually risk assessed. Policy and procedures were in place with regard to family liaison, parental consent, and confidentiality. Procedures were in place for identifying the person responsible for notifying the Mental Health Commission of the child’s admission.

Training and Education: Staff had received training in the Children First guidelines.

Evidence of Implementation: The inspection team reviewed two clinical files of children who were admitted to the approved centre since the last inspection. The children were admitted for a short duration only and did not need educational services. The approved centre was an adult facility, therefore age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of the children and to respond to the children’s’ particular needs. The children did not have access to age-appropriate advocacy services. In both cases, consent for treatment was obtained from at least one parent.

In relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated, and included segregation according to age and gender, sleeping arrangements, and bathroom areas. Staff were gender sensitive.

Both children were provided with an information booklet, and had their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical files recorded each child’s understanding of the explanation given.

Appropriate visiting times for families, including children, were available. The Mental Health Commission was notified of all children admitted to approved centres for adults within 72 hours using the appropriate notification form.

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

a) Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).

b) The children did not have access to age-appropriate advocacy services, 2.5 (g).
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission and discharge policies were reviewed in May 2019, and the transfer policy was reviewed in February 2019. The policies included all of the policy-related criteria included in the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental health illness or mental disorder. The resident was assigned a key-worker. The resident’s family member was involved in the admission process, with the resident’s consent.

The resident received an admission assessment, which included: presenting problem, past psychiatric history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information; including work situation, education, and dietary requirements. The resident received a full physical examination.

All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident, who had been discharged, was inspected. The discharge was co-ordinated by a key-worker. This was an unplanned discharge; the resident was self-discharging against medical advice after an involuntary admission order was revoked in a Mental Health Tribunal due to a technicality. This meant a discharge plan and discharge meeting were not in place as part of the individual care plan (ICP).

A discharge assessment was completed, which addressed the resident’s psychiatric and psychological needs, social and housing needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to primary care within three days. A comprehensive discharge summary was issued but not within 14 days; instead, it was issued approximately three weeks after the resident was discharged to relevant personnel. The discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, and names and
contact details of key people for follow-up. As this was a self-discharge, against medical advice, family members were not involved in the discharge process. The resident declined a follow up appointment.

The approved centre was non-compliant with this regulation because one discharge summary was not issued within 14 days, 38.3 (b).
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 19: General Health

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Two residents' general health needs were not assessed as required within six months, 19(1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Memo to all RCPs that general health assessment requirement within 6 months. IT system to flag resident within 6 months.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Quarterly audits</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>Achievable</td>
</tr>
<tr>
<td>Time-bound</td>
<td>29/11/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

| Preventative Action | Quarterly audits |
| Achievable | 31/12/2019 |
| Post-Holder(s) | Clinical Director |

### Reason ID : 10000497

<table>
<thead>
<tr>
<th>The general health assessments were not adequately completed, as not all included BMI, weight, and waist circumference, 19 (1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
</tr>
<tr>
<td>Measurable</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
</tr>
<tr>
<td>Time-bound</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
</tr>
</tbody>
</table>

| Preventative Action | Feedback on audits. Through audits |
| Achievable | 31/12/2019 |
| Post-Holder(s) | Clinical Director |

### Reason ID : 10000498

<table>
<thead>
<tr>
<th>The approved centre did not ensure access to dental services as required, 19(1)(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
</tr>
<tr>
<td>Measurable</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
</tr>
<tr>
<td>Time-bound</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
</tr>
<tr>
<td>Preventative Action</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Audits</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID : 10000501</th>
<th>The premises were not maintained in good decorative and structural condition, 22(1)(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A programme of decorative and structural works are being compiled. Anti Ligature Windows installed in St. Louise's Ward. Lino replaced in corridor in POA.</td>
</tr>
</tbody>
</table>

| Preventative Action | Monthly meetings with Technical Services | Monthly meetings with Technical Services | Achievable | 31/12/2019 | CEO |

<table>
<thead>
<tr>
<th>Reason ID : 10000502</th>
<th>There was no programme of decorative maintenance, and any decorative work was reactionary to faults and issued raised, 22(1)(c).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Works planned for upgrading Seclusion room and replacement of windows. Anti-Ligature windows replace in bedrooms of acute unit. Engaging suppliers to paint the assessment unit in St. Louises, Focus of works on anti-</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Meetings with wards, technical services to set down programme.</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Reason ID: 10000503</td>
<td>The premises were not adequately ventilated; two bathrooms were malodourous, 22(1)(b).</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Regular review of patient areas.</td>
</tr>
<tr>
<td>Reason ID: 10000504</td>
<td>The approved centre was not developed and maintained with due regard to the specific needs of residents and patients, and the safety and well-being of residents and patients. This was evidenced by the presence of numerous ligature points, 22 (3).</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Ligature audit completed and will inform and prioritise upgrade</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Ligature audit completed and will inform and prioritise upgrade</td>
</tr>
</tbody>
</table>
Regulation 26: Staffing

**Reason ID : 10000506**

Not all staff were up-to-date with training and education to enable them to provide care and treatment in accordance with best contemporary practice. Not all staff were trained in fire safety, Basic Life Support or Therapeutic Management of Aggression and Violence, 26 (4).

<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>Rolling training plan in place</td>
<td>Audits</td>
<td>Rotation of medical staff; 4 schemes roting throughout the year.</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Rolling training plan in place</td>
<td>Audits</td>
<td>Rotation of medical staff; 4 schemes roting throughout the year.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

**Reason ID : 10000508**

At the time of inspection, the approved centre did not have access to a social worker, 26(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>Corrective Action</td>
<td>Social Worker now in position.</td>
<td>Audit</td>
<td>Achievable. Filling of vacancies / leave dependent on availability of staff.</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Social Worker now in position.</td>
<td>Audit</td>
<td>Achievable. Filling of vacancies / leave dependent on availability of staff.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>
Regulation 15: Individual Care Plan

Reason ID: 10000509

Three ICPs inspected were not developed by the MDT in a timely manner, within seven days of admission. ICPs were not reviewed and updated by the resident's MDT in all cases. One ICP inspected did not contain specific, accurate, and appropriate goals for the residents. Two ICPs inspected did not clearly specify resources required to care and treat for the resident.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify deficits in audit noted and feedback to RCP with request to correct at next ICP</td>
<td>Audit</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>CD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up of an ICP Review Group to determine barriers to implementation and barriers of implementation and measures to address same. Group will comprise multidisciplinary team.</td>
<td>Audits</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>CD</td>
<td></td>
</tr>
<tr>
<td>Reason ID : 10000495</td>
<td>Code of Practice on Admission, Transfer and Discharge to and from an approved centre</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One discharge summary was not issued within 14 days, 38.3 (b).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memo to all medical staff that discharge summaries required within 14 days of discharge.</td>
<td>Yes - through audits</td>
<td>Achievable</td>
<td>06/12/2019</td>
<td>Clinical Director</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Preventative Action | Preventative action includes quarterly audits of timeframe of whether discharge summary sent within 14 days. 1st audit Qtr. 4. | Audit results | Achievable | 31/12/2019 | Clinical Director |</p>
<table>
<thead>
<tr>
<th>Reason ID: 10000499</th>
<th>COP Relating to Admission of Children under the Mental Health Act 2001.</th>
</tr>
</thead>
</table>

Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).

<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>The policy of the Hospital is not to admit children except in exceptional circumstances and is dependent on the availability of a CAMHs bed. Children admitted have 1:1 nursing; separate bathroom facilities are assigned to the child.</td>
<td>Audit post admission of child</td>
<td>31/12/2019</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The policy of the Hospital is not to admit children except in exceptional circumstances and is dependent on the availability of a CAMHs bed. Children admitted have 1:1 nursing; separate bathroom facilities are assigned to the child.</td>
<td>Audit</td>
<td>31/12/2019</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Reason ID: 10000500</td>
<td>The children did not have access to age-appropriate advocacy services, 2.5 (g).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td>-------------------</td>
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<td>---------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Audit</td>
<td>A child is only admitted on an exceptional basis. There is no age appropriate advocacy service available, however the case is referred to the CAMHs unit for their review.</td>
<td>Audit</td>
<td>Not achievable as there is no national age appropriate advocate and there can be limited access to CAMHs beds.</td>
<td>29/11/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Specific</th>
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<tr>
<td>Audit</td>
<td>A child is only admitted on an exceptional basis. There is no age appropriate advocacy service available, however the case is referred to the CAMHs unit for review.</td>
<td>Audit</td>
<td>Not achievable as there is no national age appropriate advocate and there can be limited access to CAMHs beds.</td>
<td>31/12/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to “visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate”.

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.