Tearmann Ward, St Camillus' Hospital

ID Number: AC0073

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Tearmann Ward, St Camillus' Hospital
Shelbourne Road
Limerick

Approved Centre Type: Psychiatry of Later Life

Most Recent Registration Date: 1 October 2017

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Mr Maurice Hoare, General Manager, Mid West Mental Health Services

Inspection Team:
Noeleen Byrne, Lead Inspector
Martin McMenamin
Raj Ramasawmy
Dr Susan Finnerty, MCRN009711

Inspection Date: 23 – 26 July 2019

Inspection Type: Announced Annual Inspection

Previous Inspection Date: 20 – 23 February 2018

Date of Publication: Thursday 28 November 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2019 COMPLIANCE RATINGS

REGULATIONS

- Compliant: 27
- Non-compliant: 1
- Not applicable: 3

RULES AND PART 4 OF THE MENTAL HEALTH

- Compliant: 4
- Non-compliant: 2

CODES OF PRACTICE

- 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**
Contents

1.0 Inspector of Mental Health Services – Review of Findings .................................................................5
   Conditions to registration ......................................................................................................................5
2.0 Quality Initiatives ..................................................................................................................................9
3.0 Overview of the Approved Centre ........................................................................................................10
   3.1 Description of approved centre .......................................................................................................10
   3.2 Governance ......................................................................................................................................11
   3.3 Reporting on the National Clinical Guidelines ................................................................................12
4.0 Compliance ............................................................................................................................................13
   4.1 Non-compliant areas on this inspection ..........................................................................................13
   4.2 Areas of compliance rated “excellent” on this inspection .................................................................13
   4.3 Areas that were not applicable on this inspection ...........................................................................13
5.0 Service-user Experience ......................................................................................................................15
6.0 Feedback Meeting ...............................................................................................................................16
7.0 Inspection Findings – Regulations .......................................................................................................17
8.0 Inspection Findings – Rules ................................................................................................................55
9.0 Inspection Findings – Mental Health Act 2001 ..................................................................................56
10.0 Inspection Findings – Codes of Practice .........................................................................................57
Appendix 1: Corrective and Preventative Action Plan ............................................................................60
Appendix 2: Background to the inspection process .................................................................................63
1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

Tearmann Ward had significantly improved its level of regulatory compliance since 2016. In 2018, there was 93% compliance with regulations, rules and codes of practice. In view of this achievement and in line with risk-based regulation, the annual inspection in 2019 was an announced inspection and incorporated self-assessment in all regulations, rules and codes of practice. During the annual inspection, the inspectors validated the approved centres’ self-assessments and inspected regulations, rules and codes of practice, which had a direct impact on patient care and safety.

In brief

Tearmann Ward was located in St. Camillus’ Hospital, Shelbourne Road, Limerick. It was at the rear of the campus and had its own entrance and exit foyer. The approved centre was a 15-bed assessment unit for persons with advancing dementia and psychological and behavioural symptoms. Admission was usually for a short duration, ranging from one week to a couple of months. At the time of inspection, however, four residents had been in the approved centre for more than six months.

The Psychiatry of Old Age Team provided the care and treatment for all residents and multi-disciplinary team meetings and ward rounds were held at least weekly in the approved centre. Milford Hospice Care were providing palliative care treatment and support.

In the 2019 annual inspection, Tearmann had improved its high level of compliance with regulations, rules and codes of practice to 97%, with an increased number of compliances (17) rated as excellent. There was one area of non-compliance and this was rated as moderate risk.

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

**Finding on this inspection:** The approved centre was not in breach of Condition 1; however, the approved centre non-compliant with Regulation 26: Staffing at the time of inspection.
Safety

- The approved centre had an emergency plan that incorporated fire evacuation procedures.
- All medications were ordered, prescribed, administered and stored in a safe manner.
- There was an improvement in mandatory staff training, but this was not yet compliant with Regulation 26 Staffing.
- There was adherence to food safety requirements.
- The approved centre was clean and current national infection control guidelines were followed.

Appropriate care and treatment of residents

- Each resident had a comprehensive care plan and Regulation 15: Individual Care Plan was rated as excellent on this inspection.
- The therapeutic programme was dementia specific and guided by the level of functioning assessed by the Pool Activity Level (PAL) evidence-based tool. Therapeutic services were appropriate for clients and included Speech and Language Therapy (SALT), dietetics, occupational therapy, physiotherapy and chiropody which were reflected in the individual care plans (ICPs).
- A list of all therapeutic services and programmes provided in the approved centre was available. These included reminiscence therapy, doll therapy, sand therapy, music therapy, a sensory group, and the Green Group. The Green Group was held in the refurbished garden and was facilitated by a number of staff collectively, including nursing, social work, occupational therapy, the creative arts therapist, the activities nurse, and the multi-task attendant. Garden resources were funded through the North Liberties Mental Health Association.
- Physical health of residents was regularly monitored and the clinical files also showed evidence of the provision of dietetics, physiotherapy, and speech and language therapy. An evidence-based nutrition assessment tool was used for all residents.
- The end of life care provided took into account residents’ physical, emotional, social, psychological, and spiritual needs. Privacy and dignity of the resident was respected. Family, next of kin, and friends were involved, supported, and accommodated during end of life care. Palliative care was prioritised and the palliative care team attended as required.
- The approved centre was fully compliant with all aspects of the code of practice on admission, transfer and discharge of residents.

Respect for residents’ privacy, dignity and autonomy

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents.
- Where residents shared a room, appropriate bed screening was in place to ensure that resident privacy was not compromised, and bedrooms were not overlooked by public areas.
- Public noticeboards did not display residents’ names or any identifiable information.
• Each resident had their own wardrobe and personal effects in their room and personalising of rooms with possessions and memorabilia was encouraged.

• Tearmann Ward was kept in a good state of repair externally and internally. There was a programme of general and decorative maintenance.

• There was a cleaning schedule and the approved centre was clean, hygienic, and free from offensive odours.

Responsiveness to residents’ needs

• Residents had access to space that included appropriately sized, well-lit, comfortably heated and ventilated communal rooms. There was sufficient space for residents to move about and there was an outdoor garden. Appropriate signage and sensory aids were provided to support resident orientation needs.

• There was a sufficient number of toilets and showers for residents in the approved centre including wheelchair access.

• Residents had access to a range of appropriate recreational activities. These included music and exercise groups, radio, knitting, arts and crafts, a gardening group, beauty sessions, hand massage, walking, weaving, and dancing. Residents also had access to books and magazines and to an outdoor garden. Staff also worked with individuals and provided residents with memory boxes, books, music, pictures and films. Recreational activities were facilitated on weekdays and during the weekend, and they were developed and implemented with resident and family involvement. There was a lounge area with a TV, and activities took place in this room or an adjacent room.

Governance of the approved centre

• The Mid West Mental Health Management Team (MWMHMT) of Community Health Organisation (CHO) 3 was responsible for the overall management and governance of Tearmann Ward. The local management team reported directly to the MWMHMT on any matters relating to Tearmann Ward. The Limerick Mental Health Management Team comprised heads of discipline from the medical, nursing, and allied health professional groups.

• There was strong evidence of a commitment from all staff to quality improvement and this was well-led at senior management level. The approved centre engaged with the regulatory requirements to improve quality.

• There was a schedule of audits and all clinical staff were involved in audits which were used to improve quality and to provide learning for the approved centre.

• A risk register was maintained and reviewed quarterly by the senior management team. Relevant staff had received training in the identification, assessment, and management of risk.

• Incidents were reported and documented and learning from incidents formed part of risk management.

• Complaints about the services were dealt with through the HSE procedure Your Service Your Say.

• Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile.
- Every effort was made by staff to engage residents and their families in their care and in improving the care and experience of residents. Safewards had been introduced which was a “know each other intervention” to improve the residents’ experience, to improve family engagement and breakdown barriers and to help orientate residents.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A pilot project of Hourly Rounding was introduced. It was aimed at improving awareness and reducing the occurrence of falls in Tearmann. Each hour, residents were offered a drink, checked if comfortable and footwear was checked.

2. Falls Safety Cross had been introduced. This was a visual aid to improve awareness of falls and to highlight the occurrence of falls to staff and assist in identifying patterns and trends.

3. Safewards had been introduced. This was a “know each other intervention” to improve the residents’ experience, to improve family engagement and breakdown barriers, and to help orientate residents.

4. Garden furniture was painted by trainees under the supervision of the probation service with linkages to the Limerick Scheme (PALLS Ltd), improving engagement with the wider community.

5. A Time to Unwind model was introduced. This was an intervention where staff, residents and families went to a relaxing space for a break. This was an unstructured way to engage in sensory activities. It included providing music books, a keyboard and used old pictures but activities were not prompted.

6. Dolls Therapy was introduced, which was used to decrease stress and agitation in dementia.

7. A music therapist student attended on a sessional basis. This was facilitated by an external facilitator and funded by the North Liberties Mental Health Association.

8. An art therapist student attended the approved centre and was supervised by the creative arts therapist.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Tearmann Ward was located in St. Camillus’ Hospital, Shelbourne Road, Limerick, and was under the governance and management structures of the Mid West Mental Health Services. It was situated towards the rear of the campus and had its own entrance and exit foyer.

The approved centre, which formerly had been a long-stay, continuing-care facility, was a 15-bed assessment unit for persons with advancing dementia and psychological and behavioural symptoms. All residents had been referred through their respective general practitioner to the Psychiatry of Old Age Community and Outpatient Service and, as applicable, to the approved centre for admission. Admission was usually for a short duration, ranging from one week to a couple of months. At the time of inspection, however, four residents had been in the approved centre for more than six months.

The Psychiatry of Old Age Team provided the care and treatment for all residents and multi-disciplinary team meetings and ward rounds were held at least weekly in the approved centre. Milford Hospice Care were providing palliative care treatment and support.

Structurally, Tearmann Ward dated from the 19th century. It comprised a long corridor with sleeping accommodation in five bedrooms, one single room, one double room, and three four-bed dormitories. The premises was well maintained. Colour schemes were specifically chosen for the resident profile and bed spaces and surrounding areas included personal effects and pictures. Communal areas comprised of a large seating area, a separate lounge area with television, a dining room, and an internal garden. There was no dedicated therapy room and the area provided was a thoroughfare where staff and other residents moved from one area to another. There was no multisensory room to provide non-pharmacological interventions to manage mood and behavioural problems.

Maintenance, food, and pharmacy services were all supplied to the approved centre by St. Camillus’ Hospital.

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>15</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>8</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</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>4</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 Mid West Mental Health Management Team (MWMHMT) of Community Health Organisation (CHO) 3 was responsible for the overall management and governance of Tearmann Ward. The local management team reported directly to the MWMHMT on any matters relating to Tearmann Ward. The Limerick Mental Health Management Team comprised heads of discipline from the medical, nursing, and allied health professional groups.

Tearmann Ward showed ongoing commitment in achieving compliance with regulatory standards, which they used to improve the quality of their service and to improve engagement with service users. It was evident that there was a drive to achieve a quality rating of excellent for each compliance. All staff were familiar with regulations, rules and codes of practice. Overall, there was strong evidence of a commitment from all staff to quality improvement and this was well-led at senior management level.

There was a large suite of audits covering clinical care and interventions, safety effectiveness and environment. This was managed through a schedule of audits and all clinical staff were involved in audit, which were used to improve quality and to provide learning for the approved centre.

A risk register was maintained and reviewed quarterly by the senior management team. Incidents were reported and documented and learning from incidents forms part of risk management. Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management, and clinical staff were trained in individual risk management processes. The risk management policy had been implemented throughout the approved centre.

Complaints about the services were dealt with through the HSE procedure Your Service Your Say. There was a nominated individual with responsibility for dealing with all complaints. A consistent and standardised approach was implemented for the management of all complaints. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy and the resident information pack, which included a complaint form. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives.

Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed. Staff had received training in manual handling, infection control and prevention, dementia care, end of life care, residents’ rights, risk management, incident reporting, recovery-centred approaches to mental health care and treatment and the protection of children and vulnerable adults. All staff training was documented. Not all health care professionals had up-to-date, mandatory training in Basic Life Support (BLS), the Professional Management of Aggression and Violence (PMAV) or the Mental Health Act 2001. All healthcare professionals had up-to-date training in fire safety and Children First.

Every effort was made by staff to engage residents and their families in their care and in improving the care and experience of residents. Safewards had been introduced which was a “know each other intervention” to improve the residents’ experience, to improve family engagement and breakdown barriers and to help orientate residents.
3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
</tr>
<tr>
<td>Regulation 18 Transfer of Residents</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
</tr>
</tbody>
</table>

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

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

- Posters were displayed inviting the residents or their representative to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting feedback.
- Set times and a private room were available to talk to residents or representative.

No resident met with the inspection team. Relatives met with the inspection team and said the kindness shown to the residents was much appreciated. Family members were made aware of changes and were involved in care planning. Relatives stated that staff treated residents with respect and dignity.
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:

- Head of Service
- Area Director of Nursing
- Consultant Psychiatrist
- Occupational Therapy Manager
- Assistant Director of Nursing
- Area Lead of Mental Health Engagement
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Nurse Auditor

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.
The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in June 2018. The policy addressed 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.

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

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs, were used. The preferred identifiers had not been detailed within the residents’ clinical files. Identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing health care services and therapeutic services and programmes. There was an alert system for identifying residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was 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 April 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:** Food was supplied to the approved centre by the main kitchen in St. Camillus’ Hospital. Menu plans were devised using a professional, nutritional analysis and meal plan creator tool. Menus that offered variety were developed, to suit the required needs of the residents and approved by a dietitian. There were at least two choices for meals, and food, including modified consistency diets, was attractive and appealing in presentation. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times. Hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was used for all residents. Where appropriate, weight charts were implemented, monitored, and acted upon. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian and intake and output charts were maintained, where appropriate. Nutritional and dietary needs were addressed in the residents’ individual care plans.

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*. 

**COMPLIANT**

**Quality Rating**

Excellent
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety. The Quality and Food Safety Policy was last reviewed in January 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 food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene, 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. There was suitable and sufficient catering equipment and proper facilities for the refrigeration, storage, and serving of food. Food was prepared and cooked in the main kitchen of St. Camillus’ Hospital and not in the approved centre.

Hygiene was maintained to support food safety requirements, and catering areas, and associated catering and food safety equipment were appropriately cleaned. 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 rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in June 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were wearing nightclothes during the day at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Residents had individual laundry baskets and clothes were laundered by family members. Emergency clothing was available if it was required. Residents changed out of nightclothes during the day and all residents had an adequate supply of individualised clothing.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in September 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 been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of valuables and personal effects. Access to and use of resident monies was overseen by two staff members and, when possible, a family member or resident representative. Due to the advanced dementia diagnosis for most of the residents, they were unable to sign the property checklist or countersign for monies handled by staff on their behalf.

Each resident had their own wardrobe and personal effects in their room. Staff encouraged the personalising of rooms with possessions and memorabilia. Individual property checklists were maintained. These were filed separately to each resident’s individual care plan and were available to residents.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 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 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 admission, residents had a Pool Activity Level (PAL) assessment, for occupational profiling in Dementia care. Included were residents’ likes, dislikes, routines, and current level of engagement. Information on suitable leisure activities was provided during the assessment. Residents had access to a range of appropriate recreational activities. These included music and exercise groups, radio, knitting, arts and crafts, a gardening group, beauty sessions, hand massage, walking, weaving, and dancing. Residents also had access to books and magazines and to an outdoor garden. Staff also worked with individuals and provided residents with memory boxes, books, music, pictures and films. Recreational activities were facilitated on weekdays and during the weekend, and they were developed and implemented with resident and family involvement. There was a lounge area with a TV and activities took place in this room or an adjacent room. Both of these rooms were a thoroughfare where staff and other residents moved from one area to another.

Where appropriate, individual risk assessments had been completed for residents in relation to the selection of activities. Residents’ decisions on whether or not to participate in activities were respected and documented. The recreational activities provided by the approved centre were appropriately resourced. There was a core recreational/therapeutic team consisting of an activity nurse, creative arts therapist, occupational therapist and two social workers. However outside of this group all staff participated in a degree of activities as set out in the ICP. Documented records of attendance were retained both within group records and the resident’s clinical file.

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

Regulation 10: Religion

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** Residents were facilitated to practice their religion insofar as was practicable. There was a church in St. Camillus’ Hospital and a priest visited the approved centre weekly. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. If required, residents had access to multi-faith chaplains.

The care and services provided in the approved centre were respectful of the residents’ religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

Processes:
The approved centre had a written policy and procedures in relation to visits. The policy 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 visits, as set out in the policy.

Monitoring: There were no restrictions on residents’ rights to receive visitors. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed and were appropriate and reasonable. There were no visiting restrictions for any of the residents. There were a number of areas in the approved centre where residents met visitors in private. The “snug” was dedicated as an area for children visiting. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ communication needs were assessed on admission using assessment tools including a biopsychosocial communication tool. This approach systematically considered biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery. There were no restrictions on communication since the last inspection. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to a range of communications, including telephone, e-mail, and Internet, where they had capacity to use them. The approved centre also had an iPad for resident use, if appropriate. When necessary, individual risk assessments were completed for residents with regard to their communication.

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 be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in May 2019. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in May 2019. The policy and protocols addressed requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The clinical file of two residents who had died in the approved centre were reviewed. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of residents, who were nursed in a single room. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Palliative care was prioritised and the palliative care team attended as required. The approved centre used an after death checklist and had introduced the End of Life family handover bag.

A number of residents had a Do Not Attempt Resuscitation order in place, which was documented in their clinical files. Support was given to other residents and staff following a resident’s death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.
The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 15: Individual Care Plan

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

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

INSPECTION FINDINGS

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

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

Monitoring: Residents’ ICPs were 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: Eight ICPs were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs included an individual risk management plan and a preliminary discharge plan.

Residents were assessed at admission and an ICP was drawn up by the multi-disciplinary team within seven days, following a comprehensive assessment. The ICPs identified the residents’ assessed needs and the goals and resources required to provide the care and treatment specified. The ICPs were reviewed by the MDT weekly. Because of the nature of their illness, most residents had limited input into the development of the ICP and were not offered a copy of their ICP. In all of the ICPs reviewed, there was evidence of family input and family members were offered copies of the care plan. In each case, a key worker had been identified to ensure continuity in the implementation of the ICP.

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 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 April 2018. The policy addressed all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The therapeutic programme was dementia specific and guided by the level of functioning assessed by the Pool Activity level (PAL) evidenced based tool. Therapeutic services were appropriate for clients and included Speech and Language Therapy (SALT), Dietetics, Occupational Therapy, Physiotherapy and Chiropody which were reflected in the individual care plans (ICPs).

There was no separate therapeutic room or sensory room. There was a designated activity space and measures were put in place to minimise disruption of groups, when staff or other residents needed to pass through to access other parts of the building. Physiotherapy, chiropody and other one to one services were provided in the residents’ bedroom. Residents had access to occupational therapy, social work, and clinical psychology on an individual basis, as required.

A list of all therapeutic services and programmes provided in the approved centre was available. These included reminiscence therapy, doll therapy, sand therapy, music therapy, a sensory group, and the Green Group. The Green Group was held in the refurbished garden and was facilitated by a number of staff collectively, including nursing, social work, occupational therapy, the creative arts therapist, the activities nurse, and the multi-task attendant. Garden resources were funded through the North Liberties Mental Health Association.

Records were maintained of participation and engagement in and outcomes achieved within the residents’ ICPs or clinical files. Residents had access to occupational therapy, social work, and clinical psychology on an individual basis, as required.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in February 2018. 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 interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was inspected. Communication records with the receiving facility were documented and included the reason for transfer and the resident’s care and treatment plan. Documented consent had been received from the next of kin as the resident did not have capacity to consent due to cognitive impairment. An assessment of the resident was completed prior to transfer, including a risk assessment relating to the transfer and the resident’s needs.

A letter of referral, including a list of current medications, a transfer form, and a list of required medication for the resident during the transfer process, was issued with copies retained as part of the transfer documentation. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. All records relevant to the transfer were retained in the resident’s clinical file.

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in October 2018. The medical emergencies policy was last reviewed in September 2018. Together, the policies and procedures addressed 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 policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

**Evidence of Implementation:** Staff had access to an Automated External Defibrillator and emergency bag, which had been checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents’ physical health on admission, and general health needs were managed by the non-consultant hospital doctor thereafter. At a minimum, a six-monthly health assessment had been completed. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. National screening information was available, but, at the time of inspection, this was not applicable to the resident cohort.

**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 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. The policy was last reviewed in May 2019. It addressed all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: An admission pack was provided to residents and their representatives at admission, and it included the approved centre’s information booklet. This contained details of the housekeeping arrangements such as mealtimes, the complaints procedure, visiting times and arrangements, the arrangements for personal property, and details of a relevant advocacy agency. The information pack also contained other relevant information necessary to assist the resident or their representative, including making decisions on long term care, grief and loss, legal and financial arrangements, boundaries and expectations of the service. Residents and their families were provided with information on their multi-disciplinary team (MDT).

Residents and their families received written and verbal information regarding diagnosis and the likely adverse effects of treatment, if applicable. Medication information sheets as well as verbal information were provided, and these included information on indications for use and possible side effects of medication. The information provided by the approved centre was evidence-based and had been appropriately reviewed. As required, residents had access to interpretation and translation services.

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 policy in relation to resident privacy, which was last reviewed in May 2019. The policy addressed requirements of the Judgement Support Framework, with the exception of the approved centre’s process to be applied where resident privacy and dignity is not respected by staff.

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 policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Residents wore clothing that respected their privacy and dignity. The approved centre’s layout and furnishings were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Locks had an override facility. Residents were generally accompanied by staff to bathroom and toilet facilities. Where residents shared a room, appropriate bed screening was in place to ensure that resident privacy was not compromised. Rooms were not overlooked by public areas. Public noticeboards did not display residents’ names or any identifiable information.

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

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

Monitoring: The approved centre had completed a hygiene audit. The approved centre had not completed a ligature audit. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space that included appropriately sized communal rooms, and to shared space in the form of well-lit and comfortably heated and ventilated communal rooms. There was sufficient space for residents to move about, including an outdoor garden. Appropriate signage and sensory aids were provided to support resident orientation needs.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was a cleaning schedule and the approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with heating controlled from the main hospital, instead of the resident’s own room. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Backup power was available to the approved centre.
There was a sufficient number of toilets and showers for residents in the approved centre. Wheelchair accessible toilet facilities were identified for use by residents and visitors who required such facilities. The approved centre had a designated sluice room, a designated cleaning room, and a laundry room.

There was only one single room and at the time of the inspection two residents required single rooms. This was accommodated by having one resident in a two bed ward. This was possible because the ward was not at full occupancy. There was no examination or therapy room. The approved centre provided assisted devices and equipment to address resident needs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillar.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in July 2019. It addressed requirements of the Judgement Support Framework, with the exception of the process for medication reconciliation.

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 could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All clinical staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

Evidence of Implementation: The MPARs for eight of the residents were inspected. A record of allergies or sensitivities to any medications, including if the resident had no allergies, was documented for all. The generic names of medications and preparations were written in full with dedicated spaces for routine medications, once-off medications, and “as required” (PRN) medications. The frequency of administration, the dosage, and the administration route for medications were recorded.

There was a record for all medication administered to residents. There was a clear record of the date of initiation for each medication, the route of administration and the discontinuation date. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the residents had been included in all the MPARs inspected.

All entries in the MPARs were legible and written in black ink. Medication had been reviewed at least six-monthly. Schedule 2 controlled drugs were checked by two staff members. Directions to crush medication were recorded in the respective MPARs, although the reason for same had not been documented in the clinical file. The pharmacist had been consulted about the type of preparation to be used.

Medication was stored appropriately and where medication required refrigeration, a log of the temperature of the fridge had been taken. Medication storage areas were free from damp and mould, clean, and free from litter. Food or drink was not stored in areas used for medication storage. The medication trolley was locked and stored in a locked room. Schedule 2 drugs were locked in a separate cupboard from other medicinal products. A system of stock rotation was implemented and an inventory
of medications was conducted on a monthly basis. Medication that was no longer required was returned to the pharmacy for disposal.

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 process pillar.
### Regulation 24: Health and Safety

**Regulation 24:** 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.

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy in the form of a safety statement in relation to the health and safety of residents, staff, and visitors. The safety statement was last reviewed in November 2018. It 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 safety statement. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the statement.

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

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

The approved centre was compliant with this regulation.
Regulation 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 statement adopting the HSE National Recruitment Policy (2007) and the HSE Employee Handbook as the local Policy. The statement was last reviewed in June 2019. The policy policies and procedures addressed requirements of the Judgement Support Framework, including the following:

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

The policies and procedures did not address the following:

- The roles and responsibilities in relation to staffing processes.
- The organisational structure of the approved centre, including lines of responsibility.
- The job description requirements.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The staff rota details and the methods used for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The roles and responsibilities in relation to staff training processes.
- Orientation and induction training for all new staff.
- The ongoing staff training requirements and frequency of training required to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policy.

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

**Evidence of Implementation:** There was an organisational chart identifying the leadership and management structure and lines of authority and accountability of staff in the approved centre. A planned and actual staff rota, showing the staff on duty during the day and night, was in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staff were sufficient to address the assessed needs of residents.

The approved centre had a written staffing plan, and annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed. Staff had received training in manual handling, infection control and prevention, dementia care, end of life care, residents’ rights, risk management, incident reporting, recovery-centred approaches to mental health care and treatment and the protection of children and vulnerable adults. All staff training was documented.

Not all health care professionals had up-to-date, mandatory training in Basic Life Support (BLS), fire safety, the Professional Management of Aggression and Violence (PMAV) or the Mental Health Act 2001. All healthcare professionals had up-to-date training in and Children First.

The Mental Health Act, the associated regulation, 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 mandatory training levels in the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (18 )</td>
<td>14</td>
<td>77%</td>
<td>17</td>
<td>95%</td>
<td>18</td>
</tr>
<tr>
<td>Consultant Psychiatrist (2)</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Medical (2)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Occupational Therapist (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker (2)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist (1)</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>100%</td>
<td>0</td>
</tr>
</tbody>
</table>

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

a) Not all health care professionals had up-to-date, mandatory training in Basic Life Support, fire safety, Professional Management of Aggression and Violence, and, as such, did not have access to education to enable them to provide care and treatment in accordance with best contemporary practice, 26(4).

b) Not all staff had completed mandatory Mental Health Act 2001 training, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in May 2019. The policy and procedures addressed all requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured from loss or destruction, tampering, and unauthorised access or use.

A record had been initiated for every resident in the approved centre, and these were reflective of residents’ current status and the care and treatment being provided. Resident records were maintained through the use of an identifier that was unique to the resident, in this case a combination of photograph, wristband, and date of birth. Resident records were developed and maintained in a logical sequence and they were accessible to authorised staff only.

Records were written legibly and contained factual, consistent, and accurate entries. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.
Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

The approved centre used the HSE’s National Framework for Developing Policies, Procedures, Protocols and Guidelines in relation to the development and review of operating policies and procedures required by the regulations. It was dated November 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to the development, management, and review of operating policies and procedures.
- The process for collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.

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: Frequent audits were undertaken to determine the compliance of approved centre policies with review time frames, based on the feedback from previous inspections and updated versions of the Judgement Support Framework. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures of the approved centre were developed by the Clinical Policy Procedure Protocol Group, which was made up of members of the area management team, including the area director of nursing, principal psychologist, head of occupational therapy, area lead for mental health engagement, executive clinical staff, and administrative staff.

The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Operating policies and procedures were communicated to all relevant staff.

All of the operating policies and procedures required by the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Generic policies in use were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre had a written statement to this effect, adopting the policies in question.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written statement adopting the operational policy and procedures of the HSE, Your Service, Your Say complaints process, which was dated November 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had been completed. The audits were documented and the findings acted upon. Complaints data was analysed, and required actions were identified and implemented to ensure continuous improvement of the complaints management process.

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

No complaints had been made to the nominated complaints officer for the wider service through the ‘Your Service Your Say’ process since the last inspection. Two minor complaints were handled by the approved
centres management. Details of these minor complaints and of outcomes were fully recorded and kept distinct from residents’ individual care plans.

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 32: Risk Management Procedures

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to risk management and incident management procedures, which was last reviewed in August 2017. The approved centre also referenced the addendum to HSE Integrated Risk Management Policy and Support Guidance 2017 and the Incident Management Framework for the Mental Health Division in HSE Mid-West Community Health Care 2018 which was reviewed in March 2018. The policies addressed requirements of the Judgement Support Framework, including the following:

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Relevant staff had been trained in incident reporting and documentation. 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 risk management processes, as set out in the policy. All training was documented.
Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The review measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

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

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, and in conjunction with medication requirements or administration. The multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents’ family members were offered copies of their relative’s individual care plan, which included a section on risk. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

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

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 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the main resident sitting room.

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)

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable during the inspection. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

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

INSPECTION FINDINGS

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

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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

Evidence of Implementation: Clinical files relating to three episodes of physical restraint were inspected. Physical restraint had been used in rare, exceptional circumstances and in the best interests of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated. There was evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

Physical restraint had been initiated by a registered medical practitioner, registered nurse, or other member of the multi-disciplinary team. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. The clinical practice form had been completed for each episode of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the residents’ needs and requirements in relation to the use of physical restraint. The resident’s next of kin or representative informed of the use of physical restraint and a record of the communication was placed in the clinical file. In all three episodes reviewed, there was evidence to support that a medical examination of the resident had been completed no later than three hours after the start of the episode of restraint.

The approved centre was compliant with this code of practice.
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, which were last reviewed in February 2018.

**Admission:** The admission policy addressed all of the policy-related criteria for this code of practice. These included a procedure for involuntary admission and protocols for urgent referrals, planned admissions, and timely communication with general practitioners/primary care and community mental health teams.

**Transfer:** The transfer policy addressed all of the policy-related criteria for this code of practice. These included the procedure for involuntary transfer and the roles and responsibilities of staff in relation to the transfer of residents.

**Discharge:** The discharge policy addressed all of the policy-related criteria for this code of practice. These included procedures for the discharge of involuntary patients and managing discharge against medical advice and protocols for discharging homeless people and older persons.

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

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

Evidence of Implementation:

**Admission:** One clinical file was inspected in relation to admission. The approved centre had a key worker system in place and the entire multi-disciplinary team record was contained in one set of documentation. The decision to admit was made by the consultant psychiatrist. The resident was assessed at admission, and details of all assessments were documented in the clinical file.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents.

**Discharge:** One clinical file was examined in relation to discharge. The decision to discharge was taken by the Consultant Psychiatrist and the MDT. The resident’s individual care plan contained a discharge plan. The resident was comprehensively assessed prior to discharge. The community mental health team/primary care team was informed of the discharge, and a comprehensive discharge summary was issued within 14 days.

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

**Regulation 26: Staffing**

Reason ID: 10000394

<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>A Training schedule for BLS is under development by the Practice Development Unit. The Mid West Mental Health Service is in the process of changing to an alternative fire training provider. Fire training to be scheduled for Q4 2019. PMAV training has now achieved 100% compliance since our last MHC inspection. All staff who did not have the mental health act training completed have been asked to complete HSEland</td>
<td>The Excel training database is monitored and developed and monitored by the CNM3 and this allows time for planning to ensure mandatory training is up-to-date.</td>
<td>The actions as outlined are achievable as the training database and training schedule are currently in operation. The barriers to implementation are releasing trainers from duty to deliver training and releasing staff from duty to attend training.</td>
<td>28/02/2020</td>
<td>Clinical Nurse Manager 3</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Mental Health Act training by November 2019</td>
<td>The Excel training database is monitored by the CNM3 to allow time for planning to ensure mandatory training is up-to-date. Training schedule updated regularly by CNM3 and communicated to staff in memo form.</td>
<td>When the BLS training schedule is developed, the actions are achievable and the remaining staff will be trained. Barriers to implementation are releasing BLS trainers from duty to deliver training and releasing staff from duty to attend training.</td>
<td>28/02/2020</td>
<td>Clinical Nurse Manager 3</td>
</tr>
</tbody>
</table>
twice a year to ensure all staff are trained. This is organised by the CNM3. Mental Health Act training is mandatory for all staff. New staff are provided with information on how to access HSEland in the staff induction programme.
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 recurring. 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.