Adult Acute Mental Health Unit, University Hospital Galway

ID Number: AC0105

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Registered Proprietor: HSE

Most Recent Registration Date: 30 June 2018

Inspection Team:
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Inspection Date: 15 – 18 October 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date:
27 – 30 November 2018 (Annual Inspection)
18 July 2019 (Focused Inspection)

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services, Community Healthcare West

Date of Publication: Monday 8 June 2020

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
## Contents

1.0 Inspector of Mental Health Services – Review of Findings ................................................................. 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 ..................................................................................... 11  
4.0 Compliance ............................................................................................................................................. 13  
   4.1 Non-compliant areas on this inspection ............................................................................................... 13  
   4.2 Areas of compliance rated “excellent” on this inspection ..................................................................... 14  
   4.3 Areas that were not applicable on this inspection .............................................................................. 14  
5.0 Service-user Experience ......................................................................................................................... 15  
6.0 Feedback Meeting .................................................................................................................................. 16  
7.0 Inspection Findings – Regulations ......................................................................................................... 17  
8.0 Inspection Findings – Rules ...................................................................................................................... 61  
9.0 Inspection Findings – Mental Health Act 2001 ..................................................................................... 67  
10.0 Inspection Findings – Codes of Practice .............................................................................................. 70  
Appendix 1: Corrective and Preventative Action Plan .................................................................................. 77  
Appendix 2: Background to the inspection process .................................................................................... 88
Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of the University Hospital Galway site. The approved centre was registered for 50 beds and consisted of four separate secure suites, Hazel, Ash, Holly and Oak. Thirteen consultant led teams, including Psychiatry of Later Life teams, Mental Health Intellectual Disability team, Rehabilitation and Recovery team and a Homeless Team referred residents to the approved centre.

There was a decrease in compliance with regulations, rules and codes of practice from 81% in 2018 to 67% in 2019. Eleven compliances with regulations were rated as excellent.

Conditions to registration

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

Safety in the approved centre

- The World Health Organisation Patient Safety initiative to reduce the potential for medication errors through identification of Sound-Alike-Look-Alike-Drugs (SALADs) had been implemented. Medication was ordered and stored in a safe manner.
- Weekly Health and Safety walk around of the unit were conducted. The HSE Quality and Patient Safety Directorate “Safety Pause” proactive approach to providing safe quality care had been implemented. Structural risks, including ligature points, were removed or effectively mitigated.
- Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre, as were ligature points to the lowest practicable level.

However:

- There were deficiencies in the prescription and administration of medication:
  - One medication prescription and administration record (MPAR) did not record the start date for each medication.
  - Three MPARs did not record allergies or sensitivities to medications.
  - One MPAR did not record all medications administered to a resident.
• Not all health care professionals were documented to have been trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001, and Children First.

Appropriate care and treatment of residents

• There was an excellent programme of therapeutic services which met the assessed needs of residents.

However:

• The standard of resident’s individual care plans was poor:
  
  o Eight ICPs were not developed and reviewed by a multi-disciplinary team.
  o Four of the ten ICPs reviewed did not identify appropriate goals for the resident.
  o Six of the ten ICPs reviewed did not identify the appropriate care and treatment required to meet the goals identified.
  o Nine of the ten ICPs reviewed did not identify the necessary resources required to provide the care and treatment identified.
  o Three of the entries for both the resident’s assessed needs and appropriate goals being illegible.

• An evidence-based nutrition assessment tool was not used for residents with special dietary requirements, although the approved centre’s policy on food and nutrition, the St Andrews nutritional screening instrument (SANSI), should have been completed prior to a referral to a dietitian when a nutritional concern was identified. Nutritional and dietary needs were not adequately assessed, and in one case a resident with a very low BMI had not been referred to a dietitian, or had needs addressed in residents’ individual care plans. In the case of this resident, a weight chart was not effectively implemented, monitored, and acted upon.

• Not all six-monthly general health assessments documented body-mass index, waist circumference, smoking status, nutritional status, medication review, family history, or dental checks. An electrocardiogram was not undertaken for one resident on antipsychotic medication as part of their annual health assessment.

• Nursing reviews of patients in seclusion did not always take place every two hours as required and no reason was documented as to why these did not occur within the required timeframe.

Respect for residents’ privacy, dignity and autonomy

• All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.
• The approved centre was kept in a good state of repair internally and externally and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained.

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

• There were areas where the residents could meet their residents in private.

However:

• Noise from opening and closing doors in the corridors was noted throughout the inspection. The doors were maintained with due regard to residents’ need to sleep as part of recovery. The noise from doors banging at night was described as “horrendous and dreadful” by service users.

Responsiveness to residents’ needs

• There was a choice of food at mealtimes, which was attractively presented.

• The approved centre provided access to self-directed and group recreational activities appropriate to the resident group profile on weekdays and weekends, including books, board games, and television, as well as a music group, walking group, and chair exercise group. Opportunities were provided for indoor and outdoor exercise and physical activity.

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

• There was a comprehensive complaints procedure in place.

Governance of the approved centre

• The approved centre was part of the HSE’s Community Healthcare West. Responsibilities and escalation processes within the governance structures were not clear and an organisational chart did not outline the responsibilities regarding planned and reactive maintenance. This was updated during the inspection. The Clinical Governance team met on a monthly basis and was attended by heads of discipline and services.

• Several subcommittees reported into the Clinical Governance meeting including the Health and Safety subgroup, Drugs and Therapeutics subgroup, Policy and Procedures subgroup, Audit and Quality improvement group, Clinical Charts subgroup and Clinical Complaints Committee.

• Business meetings occurred on a two monthly basis and were attended by heads of discipline and management. Standing items on the agenda included Quality, Safety and Risk, Health and Safety, Audit, and Judgement Support Framework compliance.

• The person with responsibility for risk was identified and known by all staff.

• Individual risk assessments were completed prior to episodes of physical restraint and seclusion, specialised treatments including electro-convulsive therapy, and at resident admission and transfer. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.
• The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed weekly by the multi-disciplinary team. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service.

• A six-monthly summary of incidents was provided to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with information provided anonymously at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and incorporated evacuation procedures.

However:

• There was difficulty retrieving mandatory staff training records. An updated record of mandatory training was given to the inspection team, post inspection, and it outlined that less than 50% of staff had completed some mandatory training programmes as described in the staffing table in Regulation 26.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The World Health Organisation Patient Safety initiative to reduce the potential for medication errors through identification of Sound-Alike-Look-Alike-Drugs (SALADs) had been implemented.

2. Weekly Health and Safety walk around of the unit were conducted.

3. The HSE Quality and Patient Safety Directorate “Safety Pause” proactive approach to providing safe quality care had been implemented.

4. MECC ‘Make Every Contact Count’, a Health Behaviour Change framework was implemented. Healthcare Professionals encouraged residents to make healthier lifestyle choices, during routine contacts to help prevent and manage chronic diseases.

5. The approved centre were part of the national pilot project for falls prevention. This project was undertaken in Holly Ward, Psychiatry of Later Life (POLL).
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of University Hospital Galway site. The approved centre was registered for 50 beds and consisted of four separate secure suites, Hazel, Ash, Holly and Oak. Thirteen consultant led teams, including Psychiatry of Later Life teams, Mental Health Intellectual Disability team, Rehabilitation and Recovery team and a homeless team referred residents to the approved centre.

The main door to the approved centre was locked and security staff permitted access. All doors to the wards were locked and security staff permitted entrance following visitor sign in. Hazel, Oak and Ash suites were all located on the ground floor and each had access to outdoor space. Hazel and Ash suites consisted of 18 and 19 beds respectively. The majority of bedrooms were single en suite rooms. Hazel suite contained one three-bedded and two two-bedded rooms and Ash suite contained one three-bedded room and one two-bedded room. Both Hazel and Ash suites had access to a shared area, which contained a dayroom, a games room, a dining area and a quiet room. Oak suite was a high observation unit and consisted of five single en suite rooms. Oak suite also contained a seclusion room and had access to a separate outdoor garden area.

Holly suite, located on the first floor, consisted of eight single en suite rooms and was dedicated to Psychiatry of Later Life. Residents had access to an outdoor enclosed space, which contained seating areas and multiple plant boxes. The first floor also housed administration/management offices, training rooms, an Electroconvulsive therapy (ECT) suite and therapy facilities that included a relaxation room, an art room, and a therapy kitchen. Therapy facilities were accessed by all residents of the approved centre as appropriate.

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>50</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>48</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>19</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>7</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>1</td>
</tr>
</tbody>
</table>
3.2 Governance

The approved centre was part of the HSE’s Community Healthcare West. Responsibilities and escalation processes within the governance structures were not clear and an organisational chart did not outline the responsibilities regarding planned and reactive maintenance. This was updated during the inspection and it was clarified that general maintenance was the responsibility of the CHO2 through the maintenance manager. All plant and machinery, including electrical, was managed by Saolta University Health Care Group at Galway university Hospital.

There was an ongoing issue regarding the noise levels and sleep disturbance of residents, when doors closed. Originally this query had been directed at the contractors who built the hospital. The fire officer confirmed that the use of wedges to hold doors open was not permitted as they were fire doors. Correspondence indicated that more recently the issue was directed to the company who installed the fire doors and a quotation for magnetic locks was discussed. This matter had been discussed at the monthly business meeting without resolution and escalation to the Galway Roscommon Mental Health Services Area Management Team Meeting was required in line with organisational policy. Separately a decision to open the doors from 09.00 to 17.00 was suspended as the out-patient clinic had been located in the building and there were a lot of people attending who were not residents. Residents of the approved centre accessed the upstairs activities area using the back stairs.

The Clinical Governance team met on a monthly basis and was attended by heads of discipline and services. The minutes outlined a clear agenda, actions, and a review of governance. Several subcommittees reported into the Clinical Governance meeting including the Health and Safety subgroup, Drugs and Therapeutics subgroup, Policy and Procedures subgroup, Audit and Quality improvement group, Clinical Charts subgroup and Clinical Complaints Committee. Business meetings occurred on a two monthly basis and were attended by heads of discipline and management. Standing items on the agenda included Quality, Safety and Risk, Health and Safety, Audit, and Judgement Support Framework compliance.

There was difficulty retrieving mandatory staff training records. The staffing policy and procedures stated that all training and education was recorded by heads of discipline on a register that was made available for inspection. Such records were not available and there was difficulty retrieving mandatory staff training records. An updated record of mandatory training was given to the inspection team, post inspection, and it outlined that less than 50% of staff had completed some mandatory training programmes as described in the staffing table in Regulation 26.

The Mental Health Commission’s Governance Questionnaire was issued to the approved centre. Completed questionnaires were returned by the Clinical Director, the Business Manager, the Assistant Director of Nursing, the Occupational Therapy Manager and the Director of Psychology. The Heads of Disciplines outlined regular engagement with staff and they outlined clear lines of responsibility. The retention of staff, staff training and bed capacity issues were identified, within the questionnaires, as key operational risks.

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
<td>✓</td>
<td>X Critical</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X Critical</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X Low</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 25: Use of CCTV</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X High</td>
<td>X Low</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X High</td>
<td>X High</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.
4.2 Areas of compliance rated “excellent” on this inspection

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
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<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
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<tr>
<td>Regulation 11: Visits</td>
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<tr>
<td>Regulation 12: Communication</td>
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<tr>
<td>Regulation 13: Searches</td>
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<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</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 had not admitted any children since it opened five months prior to this inspection, this regulation 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>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As no children had been admitted to the approved centre since it first opened in 2018, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents’ feedback about the approved centre. A written report was provided to the inspection team. It stated that residents enjoyed cookery, art and gardening groups. Relaxation and exercises were said to be excellent. The food was reported as being very good. Staff were excellent. Most people had private rooms which they liked and were very happy with the lovely new building and facilities. Some residents were happy that smoking was not allowed on the campus and said it was beneficial to their health. There was also feedback that some residents were unhappy with the smoking ban and said they should not be forced to quit. The fact that the doors banged when closing was mentioned and some residents said the noise kept them awake at night. There was no fresh water fonts and water was left out in jugs. Residents requested a coffee dock where they could make tea or coffee. Some residents said there was little to do at the weekends.

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

Most residents said the food was very nice and good choices were provided. Others would like a greater variety on the menu. Activities were described as excellent and there were many therapeutic groups held. There were some negative comments regarding the ability to exercise, the garden was small for walking and the gym equipment was too difficult for some to use. The noise from doors banging at night was described as “horrendous and dreadful”.

### 6.0 Feedback Meeting

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

- Area Director of Nursing
- Consultant Psychiatrist
- Acting Assistant Director of Nursing
- Business Manager
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2 x 2
- ECT Nurse
- Social Worker
- Occupational Therapist
- Staff Nurse
- Mental Health Act Administrator

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. It was agreed that the inspection team would accept an update on the staff training records and the organisational chart showing line management for maintenance and contracts. The date for acceptance was 22th October 2019 and both were received by that date.
7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in September 2019. The policy included all requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of therapeutic services and programmes, as well as other health care services. Red stickers were used to alert staff to the presence of residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all 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: Menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition. Hot and cold drinks were offered to residents regularly and a source of safe, fresh drinking water was available to residents at all times in easily accessible locations throughout the approved centre. Hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was not used for residents with special dietary requirements. As per the approved centre’s policy on food and nutrition, the St Andrews nutritional screening instrument (SANSI) should have been completed prior to a referral to a dietitian when a nutritional concern was identified. However, the clinical files of residents with special dietary requirements did not detail the use of an evidence-based nutritional assessment tool. Discussions with staff confirmed that such assessments were not usually undertaken and staff were unable on request to name the SANSI tool or where to source one. Nutritional and dietary needs were not adequately assessed, and in one case a resident with a very low BMI had not been referred to a dietitian, or had needs addressed in residents’ individual care plans. While the intake chart was monitored in the case of this resident a weight chart was not effectively implemented, monitored, and acted upon.

The needs of residents that had been identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindications with medication.
The approved centre was non-compliant with this regulation because the nutritional and dietary needs of one resident with special dietary requirements were not adequately assessed and addressed in the resident’s ICP, 5(2).
Regulation 6: Food Safety

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. There was suitable and sufficient catering equipment in the approved centre. Catering areas and associated catering and food safety equipment were appropriately cleaned. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was 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 March 2018. The policy included all requirements of the Judgement Support Framework.

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

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

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

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

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

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents were entitled to bring personal possessions with them, the extent of which was agreed at admission, and the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them and secure facilities were provided for the safe-keeping of the resident’s monies, valuables, personal property, and possessions, as necessary. Residents managed their own money and were requested not to retain large sums in the approved centre. Arrangement were made to deposit in the accounts office if necessary. The property checklist was kept separately to the resident’s ICP and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP and in accordance with the approved centre’s policy.

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the provision of recreational activities, which was dated October 2017. The policy included all requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** The approved centre provided access to self-directed and group recreational activities appropriate to the resident group profile on weekdays and weekends, including books, board games, and television, as well as a music group, walking group, and chair exercise group. Information was provided to residents in an accessible format, which was appropriate to their individual needs. The information included the types and frequency of appropriate recreational activities available within the approved centre. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement through feedback at regular community meetings.

Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Resident decisions on whether or not to participate in activities were respected and documented, as appropriate. The recreational activities provided by the approved centre were appropriately resourced and opportunities were provided for indoor and outdoor exercise and physical activity. Communal areas were also provided that were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file, as appropriate.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was dated October 2019. The policy included all requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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’ religious beliefs were assessed at admission. The residents’ rights to practice religion were facilitated and supported. Residents had access to multi-faith chaplains, if required. The hospital chaplain visited the unit periodically and on request. Holy Communion was available daily within the approved centre. Residents had access to local religious services and they were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line 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 dated June 2017. The policy and procedures included all requirements of the *Judgement Support Framework*.

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

Monitoring: 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. A separate visitors’ room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety and this was communicated to all relevant individuals publicly. The visitor room in the reception area was suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to resident communication. The policy was dated March 2017. The policy and procedures included all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents had access to mail, telephones, and their personal mobiles unless otherwise risk-assessed with due regard to the residents’ well-being, safety, and health. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and documented in the individual care plan. No resident had their communications restricted at the time of inspection.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 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 October 2018. The policy and procedures addressed all requirements of the Judgement Support Framework, including the following:

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

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

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

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the reason of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file of one resident who was searched was inspected. Risk had been assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. The resident’s consent was sought and documented, prior to the search taking place. The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident’s dignity,
privacy and gender; and at least one of the staff members who conducted the search was the same gender as the resident being searched.

Policy requirements were implemented when illicit substances were found as a result of a search. A written record of every search of a resident, and every property search was available. This included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was dated March 2018. The policy and protocols included all requirements of the Judgement Support Framework.

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Each resident in the approved centre had an ICP, ten of which were inspected. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address immediate needs of resident. The ICPs did however contain allocated space for reviews, and were identifiable, uninterrupted, stored in the clinical file, and were not amalgamated with progress notes.

Eight of the ten ICPs inspected were not developed by the full multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The comprehensive assessment included medical, psychiatric, and psychosocial history, as well as a current physical health assessment and a detailed risk assessment. Each ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. However, four of the ten ICPs examined did not appropriately identify the resident’s assessed needs or appropriate goals, with three of the entries for both the resident’s assessed needs and appropriate goals being illegible.

Six of the ICPs examined either did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment or were illegible. Nine of the ten ICPs did not sufficiently identify the resources required to provide the care and treatment identified. Six of the ICPs did not include an appropriate risk management plan, while six were not reviewed by the MDT in consultation with the resident within the required timeframe. The ICPs were updated following review, as indicated by the residents’ changing needs, condition, circumstances, and goals. A key worker was identified to ensure continuity in the implementation of a resident’s ICP and the ICPs included a preliminary discharge plan, where deemed appropriate. In two cases, the resident was not informed of any changes made to their ICP and there was no documented evidence that the two residents
were offered a copy of their ICPs, nor was there any record of the residents having refused a copy of their ICP.

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

a) ICPs were not developed and reviewed by a multi-disciplinary team.

b) Four of the ten ICPs reviewed did not identify appropriate goals for the resident.

c) Six of the ten ICPs reviewed did not identify the appropriate care and treatment required to meet the goals identified.

d) Nine of the ten ICPs reviewed did not identify the necessary resources required to provide the care and treatment identified.
### 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 May 2018. The policy included all requirements of the Judgement Support Framework.

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

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

**Evidence of Implementation:** The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of all therapeutic services and programmes was provided in the approved centre and was available to residents.

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

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

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

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

INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** The process and documentation relating to the transfer of one resident to another approved centre was examined on inspection. Communication records with the receiving facility were documented and available on inspection, including agreement of resident receipt prior to transfer. Verbal communication and liaison took place between the approved centre and the receiving facility prior to the transfer. This included a discussion of the reasons for transfer, the resident’s accompaniment requirements, and the resident’s care and treatment plan. Justification as to why there was no documented consent was available.

An assessment of the resident was not completed prior to the transfer, including individual risk assessment relating to the transfer. Full and complete written information for the resident was transferred. A letter of referral, including the list of current medications, was issued as part of the transfer documentation. A checklist was not completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. Copies of all records relevant to the resident transfer were not retained in the resident’s clinical file.

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an AED. Weekly checks were completed on the resuscitation trolley and on the AED. Records were available of any medical emergency within the approved centre and the care provided. Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care and residents received appropriate general health care interventions in line with individual care plans.

Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, but not less than every six months. The files of five residents were reviewed. The six-monthly general health assessment included a physical examination in all five cases. However, four did not include family or personal history, and four did not include body-mass index, weight, and weight circumference. Three of the five files did not record the resident’s blood pressure and three did not record a dental health review. Two files did not record the resident’s smoking status, nutritional status, or a medication review.

Four files of residents who were on antipsychotic medication were examined. There was an annual assessment of their glucose regulation, blood lipids, and prolactin levels. However, there was no record of an electrocardiogram in one of the files examined. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes according to age and gender, including Breast Check, cervical screening, retina check, and bowel screening. Information
was provided to residents regarding the national screening programmes available through the approved centre. Residents also had access to smoking cessation programmes.

The approved centre was non-compliant with this regulation because:

a) Not all six-monthly general health assessments documented body-mass index, waist circumference, smoking status, nutritional status, medication review, family history, or dental checks, 19.1(b).

b) An electrocardiogram was not undertaken for one resident on antipsychotic medication as part of their annual health assessment, 19.1(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were provided with an information booklet on admission that included details of meal times, housekeeping and personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, as well as residents’ rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team (MDT) and with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, provision of such information was prejudicial to the resident’s physical or mental health, well-being, or emotional condition.

Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side-effects, and medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.
The information in the documents provided by or within the approved centre was evidence-based and appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was 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 October 2017. The policy included all requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed 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 called by their preferred name and the general demeanour of staff was respectful, as was the way in which they addressed and communicated with residents. Staff were discreet when discussing a resident’s condition or treatment needs and sought permission before entering resident’s rooms, as appropriate. All residents were wearing clothes that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. The door to the seclusion room had a clear glass window through which other residents could observe the inside of the room. During the course of the inspection the clear glass was replaced with frosted glass. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents’ privacy and dignity was respected when in seclusion, as there was a clear glass door through which other residents could see.
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 March 2019. The policy included all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents had access to personal space and appropriately sized communal rooms were provided. There was suitable and sufficient heating in the approved centre: rooms were centrally heated, pipework and radiators were guarded, and the heating could be controlled within the residents’ own rooms. Rooms were well ventilated, lit, and appropriate signage and sensory aids were provided to support resident orientation needs. Private and communal areas were, suitably sized and furnished to remove excessive noise, however noise from opening and closing doors in the corridors was noted throughout the inspection. The doors were not developed or maintained with due regard to residents’ need to sleep as part of recovery. Sufficient spaces were provided for residents to move about, including outdoor spaces, and all resident bedrooms were appropriately sized to address the resident needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre, as were ligature points to the lowest practicable level.

The approved centre was kept in a good state of repair internally and externally and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of...
assistive equipment, for which records were maintained. There was a cleaning schedule implemented and the approved centre was clean, hygienic, and free from offensive odours. 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 and back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre and toilets were accessible, clearly marked, and close to day and dining areas. Wheelchair accessible toilet facilities were identified for use by visitors who required such facilities and there was at least one assisted toilet per floor. There was a designated sluice room and cleaning room, but not a laundry room. The approved centre had dedicated therapy and examination rooms, as appropriate. The approved centre provided suitable furnishings to support resident independence and comfort, as well as assisted devices and equipment to address residents’ needs. Remote or isolated areas of the approved centre were monitored.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs of residents and their safety and well-being. The fire doors were not maintained with due regard to the residents’ need to sleep as part of their recovery, 22(1).
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 March 2018. The policy included all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: An MPAR was maintained for each resident in the approved centre, ten of which were examined on inspection. Three MPARs did not record any allergies or sensitivities to any medications or if the resident had no allergies. One MPAR did not use a generic name for a medication, instead listing the branded name. All MPARs recorded the written names of medication and preparation in full. There was dedicated space on all MPARs for routine, once-off, and “as required” (PRN) medications. The dose to be given and the frequency of administration, including the minimum dose interval for PRN medication, was recorded on each MPAR examined.

Though a clear record of the date of discontinuation was contained in all MPARs, one did not record the date of initiation for each medication. One MPAR did not contain a record of all medications administered to the resident. MPARs did however record the administration route for medications and contained a record of any medications refused by the resident. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry was contained in the MPARs. Micrograms were not written in full on one MPAR.

All entries were legible and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident’s care or condition: this was documented in the clinical file. No prescription was altered where a changes was required. Instead, where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner.
Medicinal products were administered in accordance with directions of the prescriber and any advice provided by the resident’s pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration and expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. When a resident’s medication was withheld, the justification was noted in the MPAR and also documented in the clinical file and where the resident refused the medication, this was documented in the MPAR and clinical file and communicated to medical staff. Schedule 2 controlled drugs were checked by two staff members, one of which was a registered nurse, against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book, and following administration, the details were entered in the controlled drug book and signed by both staff members.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist, and where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily and a log was maintained on all suites of the approved centre. Medication storage areas were incorporated in the cleaning and housekeeping schedules, and were clean and free from damp, mould, litter, dust and pests, and from spillage or breakage. Food and drink was not stored in areas used for the storage of medication.

Medication dispensed or supplied to the resident was stored securely in a locked storage unit, such as a locked cupboard, trolley, and fridges, within locked clinical rooms. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security and a system of stock rotation was implemented, to avoid accumulation of old stock. A weekly inventory was not completed on all suites of the approved centre. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

a) One MPAR did not record the start date for each medication, 23(1).

b) Three MPARs did not record allergies or sensitivities to medications, 23(1).

c) One MPAR did not record all medications administered to a resident, 23(1).
Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.
(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was dated March 2017. It also had an associated safety statement, dated June 2019. The policy and the safety statement included all requirements of the *Judgement Support Framework*.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras or other monitoring systems were located throughout the approved centre. A resident was monitored solely for the purposes of ensuring the health, safety, and welfare of that resident and the use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV cameras used to observe a resident were capable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was non-compliant with this regulation because the CCTV system was capable of storing a resident’s image, 25(1)(d).
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in March 2018. The policy and procedures addressed all 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.

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: The numbers and skill mix of staffing were sufficient to meet resident needs. There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff and a planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained. All staff, including permanent, contract, and volunteers, were recruited, selected, and vetted in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment. Information from referees was sought and documented, and staff had the appropriate qualifications to do their job.

An appropriately qualified staff member was on duty and in charge at all times: this was documented. There was no written staffing plan for the approved centre, however the numbers of staff required during the day and night were documented. Where agency staff were used, there was a comprehensive contract between the approved centre and registered staffing agency used that set out the agency's responsibilities.
in relation to the vetting of staff, professional indemnity, arrangements for responding to complaints, and a confirmation of registration, identity, and staff training.

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

Staff training was not documented in accordance with policy, which stated that Heads of Discipline kept a record. Staff were contacted by their line managers, during the inspection process, and asked to provide evidence of their training. Staff had not been trained in manual handling, infection control, or dementia care, in line with assessed needs of the resident group profile. Staff were trained in care for residents with intellectual disability, end of life care, resident rights, risk management, recovery-centred approaches to mental health care and treatment and the protection of children and vulnerable adults. Staff training logs were maintained.

Training opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained and competent individuals and facilities and equipment were available for staff in-service education and training. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (66)</td>
<td>47</td>
<td>71%</td>
<td>50</td>
<td>76%</td>
<td>58</td>
</tr>
<tr>
<td>Consultant Psychiatrist (14)</td>
<td>11</td>
<td>79%</td>
<td>11</td>
<td>79%</td>
<td>6</td>
</tr>
<tr>
<td>Medical (35)</td>
<td>29</td>
<td>83%</td>
<td>20</td>
<td>57%</td>
<td>19</td>
</tr>
<tr>
<td>Occupational Therapist (3)</td>
<td>2</td>
<td>66%</td>
<td>1</td>
<td>33%</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker (10)</td>
<td>5</td>
<td>50%</td>
<td>8</td>
<td>80%</td>
<td>7</td>
</tr>
<tr>
<td>Psychologist (7)</td>
<td>4</td>
<td>57%</td>
<td>3</td>
<td>43%</td>
<td>4</td>
</tr>
</tbody>
</table>

The following is a table of clinical staff assigned to the approved centre.
There was one Clinical Nurse Manager 3 working across the four suites and one Assistant Director of Nursing working Monday-Friday.

Three Occupational Therapists and one assistant occupational therapy assistant provided a service in the approved centre. Therapy was provided across all four suites.

There was an activities nurse appointed one day per week (post 0.25).

There was an ECT nurse appointed one day per week (0.25)

There was a social worker appointed for two and a half days (0.5). Social Work services were also provided by in-reach and referral.

There was no resident psychologist within the approved centre as the person appointed (0.5) was on leave. Service was provided by in-reach and by referral.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oak Suite</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Ash Suite</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hazel Suite</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Holly Suite</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN),

- There was one Clinical Nurse Manager 3 working across the four suites and one Assistant Director of Nursing working Monday- Friday.
- Three Occupational Therapists and one assistant occupational therapy assistant provided a service in the approved centre. Therapy was provided across all four suites.
- There was an activities nurse appointed one day per week (post 0.25).
- There was an ECT nurse appointed one day per week (0.25)
- There was a social worker appointed for two and a half days (0.5). Social Work services were also provided by in-reach and referral.
- There was no resident psychologist within the approved centre as the person appointed (0.5) was on leave. Service was provided by in-reach and by referral.
a) Not all healthcare professionals had up-to-date mandatory training in Basic Life Support, fire safety, the professional management of violence and aggression, and Children First, 26(4).
b) Not all healthcare professionals had mandatory training in the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

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

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Record retention periods.
- The destruction of records.

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

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

Evidence of Implementation: A record was initiated for every resident assessed or provided with care or services by the approved centre. All residents’ records were physically stored together, secure, up-to-date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were reflective of the residents’ current status and the care and treatment being provided and maintained using an identifier that was unique to the resident. Resident records were developed and maintained in a logical sequence and in good order, with no loose pages. The records were accessible to authorised staff, who only had access to the data and information needed to carry out their job responsibilities. Residents’ access to their records was managed in accordance to the Data Protection Acts and only authorised staff made entries in residents’ records, or specific sections therein.

Records were written legibly in black, indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless
phrases. Each entry included the date, noted the time using the 24-hour clock, and was followed by a signature. The approved centre maintained a record of all signatures used in the resident record. All entries made by student nurses or clinical training staff were countersigned by a registered nurse or clinical supervisor. Where an error was made, this was scored out with a single line and the correction written alongside with the date, time, and initials. Two appropriate resident identifiers were recorded on all documentation.

Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title. In instances where information or advice was given over the phone, this was documented as such by the member of staff who took the call and the person giving the information or advice was clearly identified. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained. Records were retained or 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.
(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

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

INSPECTION FINDINGS

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

The approved centre was non-compliant with this regulation because the register did not include all of the information specified in Schedule 1 of these regulations, including the date of birth and legal status, 28(2).
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was dated June 2017. It included all requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, including services users, as appropriate, and incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The operating policies and procedures were appropriately approved and were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year timeframe. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. The format of policies and procedures was standardised and included the title of the policy and procedure, the date at which the policy was implemented, the scheduled review date, the total number of pages in the policy and procedure, its scope, as well as the document owner, approvers, and reviewers.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals, which was dated March 2017. The policy and procedures included all requirements of the Judgement Support Framework.

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

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

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in March 2019. The policy and procedures addressed all requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was not analysed.

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

Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter and was contained in the approved centre’s information booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed on notices throughout the approved centre. Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made and all complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively.
The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being made. A method for addressing minor complaints within the approved centre was provided and all minor complaints were documented. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. All non-minor complaints dealt with by the nominated person were recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s ICP. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre’s policy: this was documented in the complaints log.

Time frames were provided for responding to the complainant following the initial receipt of the complaint, the investigation period for complaints, and their required resolution. Complainants were informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented, as were the complainants’ satisfaction or dissatisfaction with the investigation findings. All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the relevant Data Protection Acts.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in March 2018. The policy addressed all 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, but not in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit 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 person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

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

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed weekly by the multi-disciplinary team. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service.

A six-monthly summary of incidents was provided to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with information provided anonymously at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
   (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
   (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated April 2019. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated suite for the delivery of ECT, including a private waiting room and adequately equipped treatment and recovery rooms. A named consultant psychiatrist and anaesthetist had overall responsibility for ECT management and anaesthesia. There were at least two registered nurses on duty in the ECT suite at all times, one of whom was a designated ECT nurse.

Materials and equipment in the ECT suite were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia, were prominently displayed. There was a facility for monitoring electroencephalogram (EEG) on two channels. ECT machines were regularly maintained and serviced and this was documented.

The clinical file of one patient who was prescribed ECT was inspected. There was an assessment of the patient’s capacity to consent by the consultant psychiatrist prior to obtaining consent. This was conducted before the first session of ECT as well as before the sixth session of ECT treatment. The patient was assessed as being unable to consent to receiving ECT treatment before the first session, and this was recorded in the clinical file. However, the patient was reassessed as being capable of consenting to treatment prior to the sixth session of ECT treatment, and this too was recorded in the clinical file.

For the first five sessions of ECT treatment, which followed the assessment that the patient did not have the capacity to consent to treatment, the ECT was administered according to section 59(1)(b) of the Mental health Act 2001, as amended, and a Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by both the consultant psychiatrists involved in the delivery of ECT.
treatment for each ECT programme. The Form 16 was placed in the patient’s clinical file and a copy was sent to the Mental health Commission within five days.

Both consultant psychiatrists assessed and recorded how ECT will benefit the patient, any discussion with and views expressed by the patient, as well as any assistance provided in relation to the discussion and the patient’s ability to consent to ECT. The programme of ECT was only prescribed by the responsible consultant psychiatrist and a prescription for the ECT was recorded in the patient’s clinical file. This record included the reason for the decision to use ECT, alternative therapies that were considered or proved ineffective, documentation of a discussion with the patient and, where appropriate, next of kin or representative.

The initial stimulus dose was discussed and considered by the treating consultant psychiatrist and the consultant psychiatrist responsible for ECT in advance of the treatment and was prescribed accordingly. The patient’s clinical status was assessed before and after each ECT treatment session and there was ongoing monitoring of the patient’s cognitive functioning throughout the ECT programme. However, a cognitive assessment, in line with international best practice, was not completed after each ECT programme. The consultant psychiatrist, in consultation with the patient, reviewed the patient’s progress and need for the continuation of ECT. The reason for the termination of the ECT programme was documented in the clinical file.

All pre-anaesthetic assessments were recorded in the clinical file and anaesthetic risk was assessed and recorded by the anaesthetist, as was the variation in risk before the ECT treatment. A consistent anaesthetic induction agent was used throughout the programme of ECT, unless contraindicated. The doses of the anaesthetic agent agents used, the patient’s response, the monitor recordings before and after treatment, and the patient’s recovery was recorded, dated, and signed by the anaesthetist and placed in the patient’s clinical file.

The patient’s clinical file and forms required by the rules were available to staff involved in ECT. ECT was only given by a registered medical practitioner - either the consultant psychiatrist or under the supervision of the consultant psychiatrist – and was administered by a constant current, brief pulse ECT machine. Stimulus dosing was used and documented in the ECT register and the ECT register was completed on conclusion of the ECT programme, with a copy placed in the clinical file. Pre-ECT assessments were placed in the clinical file, along with the ECT record completed after each treatment, which included the session number, laterality, dose, duration and quality of seizure, any complications, and the signature of the registered medical practitioner that administered the ECT. Consent was obtained for each ECT treatment session, however the consent form for anaesthesia was not complete. The renewal form for both ECT and anaesthesia was complete.

All appropriate information on ECT was given to the patient by the consultant psychiatrist once the patient was assessed to have capacity to consent to treatment prior to the sixth session of ECT and for subsequent sessions. The information included the nature of the treatment, the description of the process, its purpose and intended benefits, as well as possible consequences of not receiving ECT, alternative treatments, and a confirmation that the patient was offered alternative treatment to ECT if they decided to decline treatment.

Information was also provided on the likely adverse effects of ECT, including risk of cognitive impairment and amnesia. Information was provided both orally and in writing in clear and simple language that the patient could understand. The patient was given the opportunity to reflect on the information for 24 hours and was informed of the right to access an advocate of their choosing at any stage.
The capacity to consent prior to the sixth session and as applied to the subsequent sessions ensured that the patient could understand the nature of ECT, why it was being proposed, the broad consequences of not receiving ECT, and benefits, risks, and alternatives to the treatment. The assessment for capacity to consent also ensured that the patient could retain information long enough to make a decision on whether or not to receive ECT, make a free choice to refuse or receive the treatment, and communicate the decision to consent to ECT.

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

- Written consent for anaesthesia was not obtained when the patient had regained capacity, 3.5.
- A cognitive assessment, in line with international best practice, was not completed after each ECT programme, 6.4.
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated February 2019. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

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

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. Seclusion facilities were not furnished to ensure respect for the patient’s dignity and privacy, as the inside of the seclusion room was visible from the main corridor through the door’s glass panel. All furniture and fittings were of a design and quality so as not to endanger patient safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) and the consultant psychiatrist (CP) was notified as soon as was practicable of the use of seclusion.

When seclusion was initiated it only occurred after an assessment, including a risk assessment, and the initiation of seclusion was recorded in clinical file and seclusion register by the person who initiated the seclusion. The seclusion order was recorded in the clinical file and seclusion register by an RMP, who indicated the duration of the seclusion order of not more than eight hours. The seclusion register was signed by the responsible CP or duty CP within 24 hours of the initiation of seclusion and a medical review of the patient was conducted no later than four hours after the commencement of the episode of seclusion.

The clinical files of three residents who had been in seclusion were examined on inspection. In all three cases, seclusion was used in rare and exceptional circumstances and in the resident’s best interests, when the resident posed an immediate threat of serious harm to themselves or to others. All other interventions
to manage the resident’s unsafe behaviour had been considered before deciding to use seclusion, and where close confinement was contraindicated, seclusion was only used when all other options had proven unsuccessful. All uses of seclusion were clearly recorded in the resident’s clinical file. Cultural awareness and gender sensitivity were demonstrated through the three episodes of seclusion examined and the residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of seclusion. The residents’ next of kin or representative were informed of the seclusion as applicable and, where this had not happened, a reason was recorded in the clinical file.

The resident’s clothing respected their right to dignity and privacy and, where clothing was not worn, the reason was documented in the individual care plan. When they were conducted, bodily searches respected the resident’s dignity, bodily integrity, and privacy. In all three episodes, there was direct observation by a registered nurse for the first hour following the initiation of seclusion, with continuous observation thereafter and where applicable. There was a written record of the resident for every fifteen minutes they were in seclusion and this included the level of distress and behaviour. Not all nursing reviews took place every two hours in each of the three episodes and no reason was documented as to why these did not occur within the required timeframe.

A medical review by an RMP had taken place every four hours in each of the three episodes. Where there was a renewal of the seclusion order beyond 24 hours, as in two of the episodes reviewed, a CP examined the resident and recorded a physical examine in the resident’s clinical file. Each resident was informed of the ending of the episode of seclusion and the reason was recorded in their clinical file. All uses of seclusion were clearly recorded on the seclusion register; however, in one of the episodes of seclusion, eight copies of the seclusion register were not placed in the resident’s clinical file. Each episode of seclusion was reviewed by members of the multi-disciplinary team and was documented in the clinical file within two working days after the episode of seclusion.

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

a) It was not evident in three episodes of seclusion that a nursing review of the patient in seclusion took place every two hours, nor was any justification provided in the event that to do so would have placed the patient or staff at a high risk of injury, 5.3.
b) A copy of the seclusion register was not placed in a resident’s clinical files on eight occasions, 9.3.
9.0 Inspection Findings – Mental Health Act 2001

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

One patient had capacity to consent to medication. A written record of consent detailed the names of the medications prescribed and contained a confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications. It also documented details of a discussion with the patient, including the nature and purpose of the medications, the effects of medications, such as the risks and benefits and any views expressed by the patient, as well as any supports provided to the patient in relation to the discussion and their decision-making.

In two cases the patient did not have capacity to consent to the continued receipt of medication and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed in each case. In both cases, the forms contained the names of the prescribed medications and a confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications. The form also contained the details of a discussion with the
patient, including the nature and purpose of the medications, the effects of medications, any views expressed by the patient, and any supports provided to the patient in relation to the discussion and their decision-making. The form documented the approval by a consultant psychiatrist and the authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2019. It addressed the following:

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

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

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

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. In all cases, physical restraint was initiated by an appropriately qualified health professional. Physical restraint was used in rare and exceptional circumstances only when the resident posed an immediate threat of serious harm to themselves or others. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

In all cases, a designated staff member was responsible for leading in the physical restraint of the resident and for monitoring their head and airway. The consultant psychiatrist or the duty consultant psychiatrist was notified as soon as was practicable and this was recorded in the clinical file. A registered medical practitioner completed a medical examination of the resident no later than three hours after the start of the episode of physical restraint in all three cases. The order for the physical restraint lasted for a maximum of 30 minutes and the episode was recorded in the clinical file.

In each case, a clinical practice form was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode; the form was subsequently signed by the consultant psychiatrist within 24 hours. All three residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint, unless the information was prejudicial to their mental health, well-being, or emotional condition. Where applicable, and with the resident’s consent, the resident’s next of kin or representative was informed of the use of physical restraint, with the record of the communication recorded in the clinical file. Where the resident had capacity and did not consent to informing their next of kin, this was recorded in the clinical file. Staff were aware of relevant considerations in the resident’s individual care plan pertaining to their requirements in relation to the use of physical restraint.

Where practicable, same sex staff members were present at all times in all cases of physical restraint reviewed. Each resident was afforded the opportunity to discuss the episode of physical restraint with members of the multi-disciplinary teams involved in their care as soon as was practicable. A completed clinical practice form was placed in the clinical file. Each episode of physical restraint was reviewed by
members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated April 2019. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk residents were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had responsibility for ECT management, and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary resident who was receiving ECT were examined. The consultant psychiatrist assessed the resident’s capacity to consent to receiving treatment, and this was documented in the resident’s clinical file. The resident was deemed capable of consenting to receiving ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the resident to make a decision on consent. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side effects. Information was provided both orally and in writing, in a clear and simple language that the resident could understand. The resident was informed of their rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia.

A programme of ECT for the resident was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the resident and their next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine.

The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioner administering ECT was detailed. All pre and post ECT assessments
were detailed and recorded in the clinical file. Copies of all cognitive assessments were placed in the clinical file.

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

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in September 2019, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in March 2018, included all of the policy-related criteria for this code of practice.

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

Monitoring: While an audit had been completed on the implementation of and adherence to the admission and discharge policies, it had not been completed for the transfer policy.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The resident received a full physical examination and their family member, carer, or advocate were involved in the admission process with the resident’s consent.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by a key worker. The discharge plan included the estimated date of discharge and documented communication with the relevant general practitioner, primary care, or Community Mental Health Team (CMHT), as well as a follow-up plan and a reference to early warning signs of relapse and risks. A discharge meeting attended by the residents, their key worker, relevant members of the multidisciplinary team, and the resident’s family, carer, or advocate, where appropriate, was held.

The resident’s discharge assessment addressed psychiatric and psychosocial needs, a current mental state examination, a comprehensive risk assessment and risk management plan, social housing needs, and informational needs. A preliminary discharge summary was not sent to the general practitioner, primary care, or CMHT within three days. A comprehensive discharge summary was issued within 14 days. The
discharge summaries included details of the resident’s diagnosis, prognosis, medication, mental state at discharge, and follow-up arrangements. It did not, however, include the resident’s outstanding health or social issues, the names and contact details of key people for follow-up, nor any risk issues, such as signs of relapse. A family member, carer, or advocate was involved in discharge process, where appropriate, and there was a timely follow-up appointment.

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

a) There was no audit of the implementation of and adherence to the transfer policy, 4.19.

b) The discharge summary did not include details of outstanding health or social issues, 38.4.

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

d) The discharge summary did not include details of risk issues, such as signs of relapse, 38.4.

e) A preliminary discharge summary was not sent to the general practitioner, primary care, or Community Mental Health Team within three days, 38.3.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 15: Individual Care Plan

<table>
<thead>
<tr>
<th>Reason ID: 10000999</th>
<th>ICPs were not developed and reviewed by a multi-disciplinary team.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All MDT members to document their attendance at MDT.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>All MDT members to document their attendance at MDT.</td>
<td>Quaterly Audit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations. Ongoing training and education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations. Ongoing training and education.</td>
<td>Measurable.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Reason ID: 10001000</th>
<th>Four of the ten ICPs reviewed did not identify appropriate goals for the resident. Six of the ten ICPs reviewed did not identify the appropriate care and treatment required to meet the goals identified. Nine of the ten ICPs reviewed did not identify the necessary resources required to provide the care and treatment identified.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Memo from CD to all clinical staff regarding the importance of documenting appropriate goals, appropriate care and treatment and resources required. Assign lead to coordinate the non compliance of audit findings to relevant Heads of Discipline.</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Memo from CD to all clinical staff regarding the importance of documenting appropriate goals, appropriate care and treatment and resources required. Assign lead to coordinate the non compliance of audit findings to relevant Heads of Discipline.</td>
<td>ICP to be audited on a quarterly basis. 2nd April, 2nd June, 2nd September, 2nd December.</td>
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<tr>
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<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations. Ongoing training and education.</td>
<td>Measurable. Audit.</td>
</tr>
</tbody>
</table>
### Regulation 19: General Health

**Reason ID : 10000990**

An electrocardiogram was not undertaken for one resident on antipsychotic medication as part of their annual health assessment, 19.1(b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Memo from CD has been sent to all medical staff. The importance of fully completing medical assessments. Training provided by CD to medical staff on the importance of completing physical assessment documentation inclusive of ECG’s as per the proforma document and same to be filed in the investigation section of the patient clinical file.</td>
<td>Results of health assessments to be presented at MDT meetings. Audit.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
</tr>
</tbody>
</table>

| **Preventative Action** | The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations. Training to postgrads as part of their teaching sessions including induction training. Mental Health Act Administrator will continue to remind treating team of forthcoming physical assessments. | Measurable. | Achievable. | 28/08/2020 | Snr. Registrar. Mental Health Act Administrator. |
**Regulation 21: Privacy**

<table>
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<tr>
<th>Reason ID : 10001003</th>
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The registered proprietor did not ensure that residents' privacy and dignity was respected when in seclusion, as there was a clear glass door through which other residents could see.

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<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The door has the privacy frosted film on the glass panel in the door.</td>
<td>Completed.</td>
<td>Realistic.</td>
<td>01/01/2020</td>
<td>Registered Proprietor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPA completed.</td>
<td></td>
<td>Complete.</td>
<td>Realistic.</td>
<td>01/01/2020</td>
<td>Registered Proprietor.</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

**Reason ID: 10000993**

The registered proprietor did not ensure that the condition of the physical structure and the overall environment was developed and maintained with due regard to the specific needs of residents and their safety and well-being. The fire doors were not maintained with due regard to the residents' need to sleep as part of their recovery, 22(1).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Following a meeting of the Capital Spending Group the exact specifics of remedial works required to fire doors in the AAMHU have been forwarded via Maintenance (following a complete assessment of all doors) to Estates. Estates have been requested to engage an Architect/engineer to carry out a detailed survey of all the doors with agreement that any snags/defects noted will be repaired/replaced. Await update from Estates.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/03/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>All staff to be vigilant and aware when utilising doors.</td>
<td>Health and Safety walkabout and documentation of same. Audit.</td>
<td>awaiting response.</td>
<td>28/03/2020</td>
</tr>
</tbody>
</table>
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

**Reason ID : 10000994**

<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>Memo from CD to all medical staff with regards to the importance of documenting all start dates, allergies or sensitivities to medication whether known or not. Memo from CNM3 to Nursing Staff regarding the importance of recording all medications administered to resident. Audit Committee to undertake audit every three months by Pharmacist.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/05/2020</td>
<td>Clinical Director CNM3 Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/05/2020</td>
<td>Chair of the Local Audit Committee.</td>
</tr>
</tbody>
</table>
### Regulation 25: Use of Closed Circuit Television

<table>
<thead>
<tr>
<th>Reason ID: 10000982</th>
<th>The CCTV system was capable of storing a resident's image, 25(1)(d).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Current CCTV system does not record. Neither is it connected to any hard drive. However, engagement continues with IC Services (provider of CCTV in AAMHU) to ensure that the &quot;capability to record&quot; is removed from the CCTV system. Solutions have been identified including removing existing TV and fixing a record video matrix at the nurses station. Continue to engage with IC Service and AAMHU to identify best solution.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Vigilance and awareness from all Staff members. Monthly checks on CCTV.</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Reason ID : 10000997**

Not all healthcare professionals had up-to-date mandatory training in Basic Life Support, fire safety, the professional management of violence and aggression, and Children First, 26(4). Not all healthcare professionals had mandatory training in the Mental Health Act 2001, 26(5).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Heads of Discipline to ensure relevant staff complete mandatory training.</td>
<td>Measurable. Certificates of completion to be collated and available to Inspectors.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Regular training needs analysis to identify training deficits and a schedule of training circulated to staff.</td>
<td>Measurable. As per above.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
</tr>
</tbody>
</table>
**Regulation 28: Register of Residents**

**Reason ID : 10000983**

The register did not include all of the information specified in Schedule 1 of these regulations, including the date of birth and legal status, 28(2).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>31/08/2020</td>
<td>CNM3</td>
</tr>
<tr>
<td>A revised recording register has been developed and ordered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Preventative Action | Audit. | Achievable. | 31/08/2020 | CNM3 |
| To continue monitoring that all information is included. The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points based on the findings of the MHC regulations. |
## Rules Governing the Use of Electro-Convulsive Therapy

### Reason ID: 10000991

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Checklist completed for consent for Consultants and Anesthesia before service user commences treatment.</td>
<td>Audit</td>
<td>Achievable</td>
<td>28/08/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Education provided to all Consultants and discussed at Team meetings regarding ECT guidelines and follow up post discharge.</td>
<td>Audit</td>
<td>Achievable</td>
<td>28/08/2020</td>
</tr>
</tbody>
</table>

### Reason ID: 10000992

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Audit stickers completed on each Patient's clinical file for team to review.</td>
<td>Audit</td>
<td>Achievable</td>
<td>28/08/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Presentation on ECT given to NCHD's on their induction day regarding ECT guidelines, referral process, physical investigations and cognitive assessments. Education and training provided to all clinical Staff.</td>
<td>Audit</td>
<td>Achievable</td>
<td>28/08/2020</td>
</tr>
</tbody>
</table>
## Rules Governing the Use of Seclusion

### Reason ID: 10001005

It was not evident in three episodes of seclusion that a nursing review of the patient in seclusion took place every two hours, nor was any justification provided in the event that to do so would have placed the patient or staff at a high risk of injury, 5.3.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Seclusion pathway is now implemented which includes a field that reminds Nursing to complete nursing review every two hours. Memo to nursing staff to state that a nursing review does not take place that a justification is provided in the observation sheet within the pathway.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/05/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations. Ongoing training and education with all staff.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/05/2020</td>
</tr>
</tbody>
</table>

### Reason ID: 10001006

A copy of the seclusion register was not placed in a resident's clinical files on eight occasions, 9.3.

<table>
<thead>
<tr>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Memo to all clinical staff to place copy of seclusion register in Clinical File once completed.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/05/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations. Ongoing training and education.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/05/2020</td>
</tr>
<tr>
<td>Reason ID: 10000984</td>
<td>There was no audit of the implementation of and adherence to the transfer policy, 4.19.</td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------------------------</td>
<td>----------</td>
<td>------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Audit was completed on the 26.01.2020.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>26/01/2020</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points on findings from MHC regulations.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>26/07/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000985</th>
<th>The discharge summary did not include details of outstanding health or social issues, 38.4. The discharge summary did not include details of names and contact details of key people for follow-up, 38.4. The discharge summary did not include details of risk issues, such as signs of relapse, 38.4.</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>Corrective Action</td>
<td>The importance of completion of the discharge summary to include details of name, contact details of key people for follow up, outstanding health and social issues and details of risk issues such as relapse.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
<td>Snr. Registrar</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Ongoing education and training also as part of induction training of NCHD’s.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
<td>Snr. Registrar</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000988</th>
<th>A preliminary discharge summary was not sent to the general practitioner, primary care, or Community Mental Health Team within three days, 38.3.</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>Corrective Action</td>
<td>The preliminary discharge summary to be sent to GP, Primary Care and Community Mental Health Teams within specific timeframes.</td>
<td>Audit.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
<td>Snr. Registrar, NCHD’s.</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Education and Training. Also as part of the induction training for NCHD’s. The local audit committee have established a communication pathway which involves the circulation of a slide with teaching points based on the Mental Health Commission Regulations.</td>
<td>Measurable. Audit.</td>
<td>Achievable.</td>
<td>28/08/2020</td>
<td>Snr. Registrar, NCHD’s.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

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

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

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

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

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

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

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

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

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

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