Acute Psychiatric Unit 5B, University Hospital Limerick

ID Number: AC0002

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Psychiatric Unit 5B, University Hospital Limerick Dooradoyle Limerick

Conditions Attached: Yes

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: 1 March 2017

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

Inspection Team: Marianne Griffiths, Lead Inspector Susan O’Neill Sarah Moynihan Carol Brennan-Forsyth

Inspection Date: 18 – 21 June 2019

Previous Inspection Date: 20 – 23 November 2018

Inspection Type: Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Friday 28 February 2020

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

Inspector of Mental Health Services
Dr Susan Finnerty

In brief

The Acute Psychiatric Unit 5B was located within the University Hospital Limerick in Dooradoyle. It was registered to provide Acute Adult Mental Health Care, Mental Health Rehabilitation, Psychiatry of Later Life (POLL) and Mental Health Care for People with Intellectual Disability. Seven clinical teams admitted residents into the approved centre.

The High Observation unit had never been commissioned and there were no plans to open it in the immediate future. This affected the availability of space and accommodation for residents in the main approved centre.

The approved centre continued to provide care to three service users who were inappropriately placed. As two of these residents were living in the Psychiatry of Later Life ward indefinitely, this section of the approved centre could not be utilised as a separate five bedded section to facilitate the care of older aged residents.

Compliance with regulations, rules and codes of practice was 71%, the same compliance rate as in 2018. There had been an overall improvement in compliance since 2017, when compliance was 51%. Five compliances with regulations were rated excellent.

Conditions to registration

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

**Condition 1:**
To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

The approved centre was not in breach of Condition 1, but was non-compliant with Regulation 15: Individual Care Plan for the third consecutive year.

**Condition 2:**
To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.
The approved centre was not in breach of Condition 2, but was non-compliant with Regulation 22: Premises for the third consecutive year. It was also non-compliant with Regulation 21: Privacy.

**Condition 3:**
*To ensure a comprehensive risk management policy is implemented in the approved centre in adherence to Regulation 32(1) and (2), the approved centre shall submit a copy of their risk register to the Mental Health Commission in a form and frequency prescribed by the Commission.*

The approved centre was not in breach of Condition 3, but was non-compliant with Regulation 32: Risk Management Procedures on this inspection.

**Safety in the approved centre**

- Appropriate hand washing areas were provided for catering services and there was suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Hygiene was maintained to support food safety requirements and catering areas were appropriately cleaned. Food was prepared in a manner that reduced the risk of contamination, spoilage and infection.
- The ordering, prescribing, storing and administration of medication was managed in a safe manner.

However:

- Not all staff had been trained in fire safety, Basic Life Support (BLS), prevention and management of aggression and violence and the Mental Health Act 2001.
- Residents were smoking on the premises which constituted a risk, particularly at night time.
- The High Dependency Unit, with beds for eight residents, remained closed at the time of the inspection. This closure impacted upon the capacity of the remainder of the approved centre and impacted upon the risk management strategies used for residents.
- Observations on walkabout and the approved centre’s own ligature audit indicated that ligature risks remained within the approved centre. The policy of locking bedroom doors during the day went some way to mitigating these risks, however the risks remained at other times.

**Appropriate care and treatment of residents**

- Individual care plans (ICPs) were developed and reviewed by the multi-disciplinary team with input from the resident involved.
- The therapeutic services and programmes provided by the approved centre were evidence based, were appropriate and met the assessed needs of the residents as documented in their individual care plans. Residents had access to occupational therapists, psychologists, a speech and language therapist and social workers. Art therapy and music therapy were delivered in the approved centre.
- There were adequate arrangements in place for residents to access general health services and for their referral to other health services.
- Residents identified as having special nutrition requirements were regularly reviewed by a dietician.

However:
• One of the ten ICPs inspected was not put in place until 11 days after the resident’s admission. On the same clinical team, a resident’s ICP was not reviewed within the weekly timeframe as would be expected for a resident with acute care needs.

• There was a lack of assessment of residents’ general health needs:
  o Three general health checks had not been completed within the required 6 month timeframe.
  o Two general health checks did not include a record of family history.
  o Three did not document resident weight, Body Mass Index or waist circumference.
  o None of the files inspected contained a record of the residents’ smoking status.
  o One of the files omitted nutritional status.
  o One file was missing the resident’s dental check.
  o The files of three residents who were on antipsychotic medication were examined. One of the files did not include blood glucose, blood lipids, an ECG or a test of prolactin levels.

• Three children had been admitted to the approved centre since the last inspection. As Unit 5B Limerick was an adult approved centre, age-appropriate facilities and a programme of activities appropriate to children were not provided. Provisions were in place to ensure the safety of the child and respond to the child’s special needs as a young person in an adult setting.

Respect for residents’ privacy, dignity and autonomy

• Visiting times were publically displayed within the approved centre and these times were reasonable and appropriate. At the time of the inspection no residents had visitor restrictions in place. A separate visitors’ room was provided to accommodate residents wishing to meet with visitors in private.

• The file of a resident who had recently been searched was examined as part of the inspection process. Resident consent was sought prior to searches taking place which was implemented with due regard to the resident’s dignity, privacy and gender.

• All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door. Where residents shared a room or dormitory, bed screening ensured that their privacy was not compromised. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

• The approved centre was in a good state of repair at the time of the inspection. A number of maintenance issues were noticed by the inspection team on the first day and these were addressed prior to the last day of the inspection. There was a programme of general maintenance in the approved centre.

However:

• The main sitting room was bare and stark in appearance. It was also a thoroughfare to the outdoor area where residents could smoke. The sitting room smelt of smoke as the adjoining door to the smoking area was often left open. The main sitting room of the approved centre was cold during the inspection. One blind on an internal window was broken leaving the inside of a dorm visible from a public area of the unit.

• The premises were observed to be unclean in some areas – particularly the fridge and the sink in the pantry within the POLL ward. One outdoor area contained litter such as cigarette butts and one toilet was observed to be malodorous. There was graffiti noted on the wall of the outdoor area next to the Psychiatry of Later Life area. The plant beds in all of the gardens were overgrown with weeds.
- The ‘locked bedroom door policy’ within the approved centre meant that residents were opting to rest and sleep on couches in the public areas of the approved centre. Residents were lying on furniture and attempting to rest in communal spaces during the day. This practice was not conducive to maintaining resident privacy and dignity in the approved centre. Two residents were dissatisfied with the approved centre policy of locking the bedroom doors during the day.

Responsiveness to residents’ needs

- Residents were provided with a variety of wholesome and nutritious food. Menus were approved by a dietician. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour and appearance.
- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend; however, the provision of weekend activities was dependent upon the availability of staff. The approved centre provided residents with opportunities for indoor activities; residents had access to a gym which contained a treadmill, boxing bag, weights and an exercise bike.
- The lack of access to outdoor space meant that residents did not have opportunities for outdoor exercise.
- Required information was provided to residents and their representatives at admission; this included an information pack that detailed the care and services provided by the approved centre.
- There was a nominated person responsible for dealing with all complaints available to the approved centre. A consistent and standardized approach was implemented for the management of all complaints and complaints processes was well publicised and accessible to residents and their representatives.

However:

- Residents were not provided with written and verbal information on diagnosis. Medication information sheets were not consistently provided to residents.

Governance of the approved centre

- The Mid West Mental Health Services Management Team governed the entire regional mental health service. Items discussed at their meetings pertaining to the approved centre included: the Mental Health Commission inspection results as well as the layout, the locked door policy and the ongoing programme of audits. There was also the approved centre management team which met fortnightly.
- All department heads had received training in risk management and each visited the approved centre on a regular basis. Each department monitored its own performance in different ways and supervision structures were in place in varying degrees of formality. There was no established performance appraisal system in place for staff within the approved centre.
- The approved centre was represented upon various committees, allowing for the escalation of risk issues within the service. The Limerick Regional Health and Safety group discussed matters such as the approved centre Safety Statement audits, local health and safety initiatives, the availability of training and reports on Health & Safety walkabouts. The Limerick Mental Health Quality and Safety Management meeting took place each month. These meetings were an opportunity to review items
that had been communicated to the committee through the approved centre risk management process.

However:

- The approved centre did not have an up-to-date certificate of registration with three conditions to registration attached. The first page of the certificate was displayed prominently at the entrance to the approved centre; however, the second page of the certificate of registration was not displayed at the time of the inspection.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Tai chi had been introduced as part of the therapeutic group programme on the unit.

2. Recent expansion of the SafeWards initiative had a positive impact on the delivery of care to residents. Residents were encouraged to leave messages on the discharge tree as they left the unit.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Inpatient mental health services for the Limerick catchment area were provided by Unit 5B Limerick. This approved centre was located within the University Hospital Limerick in Dooradoyle, close to the city centre.

The approved centre was registered to provide Acute Adult Mental Health Care, Mental Health Rehabilitation, Psychiatry of Later Life and Mental Health Care for People with Intellectual Disability. The main approved centre comprised of 4, 5 and 6 bedded dormitory style accommodation as well as two rooms each containing 2 beds and 3 single rooms. The approved centre had a large activities area which included: an art room, a large sitting room, a recreation room, a gym and a Hair and Beauty room.

The 5 bedded Psychiatry of Later Life (POLL) unit was currently being occupied by two residents both of whom had an intellectual disability and were awaiting long term residential placements. As a result the POLL unit was not available to provide separate accommodation for older aged residents. The High Observation unit contained a seclusion room and 8 single bedrooms that were out of commission at the time of the inspection. This area had never been operational as a high observation unit and there were no plans to open it in the immediate future. A third resident, also anticipating a long term placement, was cared for in part of this area during the day. The lack of availability of a POLL unit and a high dependency unit impacted upon the availability of space and accommodation for residents in the main approved centre.

The Sector teams that admitted residents into the approved centre included: Tevere (Limerick north), St. Anne’s (East county Limerick), Willowdale (Limerick city centre and west city), Churchtown (Limerick west) and Killmallock (Limerick south). Residents from the Rehabilitation and Old Age teams were also admitted to the approved centre. At the time of the inspection, only one team (Killmallock) was fully staffed with allied health professional, nursing and medical staff; all of the remaining teams had at least one vacancy.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
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<tbody>
<tr>
<td>Number of registered beds</td>
<td>42</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>37</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>11</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>10</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>2</td>
</tr>
</tbody>
</table>
3.2 Governance

The approved centre was represented upon various committees, allowing for the escalation of risk issues within the service. The Limerick Regional Health and Safety group discussed matters such as the approved centre Safety Statement audits, local health and safety initiatives, the availability of training and reports on Health & Safety walkabouts. The Limerick Mental Health Quality and Safety Management meeting took place each month. These meetings were an opportunity to review items that had been communicated to the committee through the approved centre risk management process. The approved centre ‘locked bedroom door’ policy was discussed at these meetings on an ongoing basis.

The Mid West Mental Health Services Management Team were in charge of the entire regional mental health service. Items discussed at their meetings pertaining to the approved centre included: the Mental Health Commission inspection results as well as the layout, the locked door policy and the ongoing programme of audits. There was also a fortnightly meeting of the Limerick management team of the approved centre. The minutes of the most recent meetings were reviewed and these evidenced ongoing discussions about the difficulties in assigning one medical clinician to the approved centre and the ongoing issues with regards to the nursing staff for the High Observation Unit.

The Heads of Discipline for the Nursing, Occupational Therapy, Psychology and Social Work departments returned the Mental Health Commission governance questionnaire as requested. Heads of Discipline also made themselves available to speak with the Lead Inspector during the inspection of the approved centre.

All department heads had received training in risk management and each visited the approved centre on a regular basis. Each department highlighted ‘staffing’ as an operational risk, with the Social Work department identifying the lack of training budget as potentially problematic. Other risks identified by the Area Director of Nursing included: the continued closure of the High Observation unit and the risks resulting from three inappropriate long stay admissions. Each department monitored its own performance in different ways and supervision structures were in place in varying degrees of formality. There was no established performance appraisal system in place for staff within the approved centre.

The continued inappropriate placements of three residents within the approved centre had potentially negative implications for the care delivery and risk management within the service. The inspection team were struck by the lack of cohesion within the overall management team; specifically a notable lack of visibility in terms of the medical team management.

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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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X High</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X Critical</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓ Moderate</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 34: Certificate of Registration</td>
<td>✓</td>
<td>✓</td>
<td>X Low</td>
</tr>
<tr>
<td>Code of Practice on the Admission of Children under the Mental Health Act 2001</td>
<td>X High</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 Moderate</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
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</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

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<td>Regulation 4: Identification of Residents</td>
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<td>Regulation 7: Clothing</td>
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<td>Regulation 8: Residents’ Personal Property and Possessions</td>
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<td>Regulation 10: Religion</td>
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<td>Regulation 30: Mental Health Tribunals</td>
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</tbody>
</table>

4.3 Areas that were not applicable on this inspection
<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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

Seven residents spoke with the inspection team over the course of the inspection. Residents were complimentary of the care delivered by nursing staff. Two residents were dissatisfied with the approved centre policy of locking the bedroom doors during the day. The Advancing Recovery in Ireland Education Service (ARIES) programme, which promoted recovery based strategies, was received very well by residents. Discussions pertaining to various complaints that had been filed with the approved centre prompted the inspection team to follow up these complaints and to ensure that these complaints had been escalated correctly.

The advocate had the following feedback:

- Several residents reported that the approved centre had improved hugely since they were last there several years ago. The gym, Beauty Room and dog therapy were very popular. Feedback on the food was quite positive and the Safe Wards initiative has changed the culture of the unit for the better.
- Some residents commented that more activities at the weekend would be welcomed and that property can go missing at times on the unit and is difficult to locate.

Two completed resident information leaflets were returned to the inspection team. These information leaflets presented both positive and negative feedback about the approved centre.
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:

- Executive Clinical Director
- Clinical Director
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Mental Health Act Administrator
- Clinical Nurse Manager 1
- Occupational Therapy Manager
- Area Director of Nursing
- Area Lead for Mental Health Engagement
- Registered Proprietor Nominee
- Head of Psychology

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. Some clarifications were made in relation to the inspection team findings and a discussion about the ‘locked bedroom door’ policy took place. The risks around resident smoking in the approved centre and those posed by the continued accommodation of residents who are ready for discharge were discussed. The management staff acknowledged the challenges facing the approved centre building and outlined the plans to adapt the resident sitting room.
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 June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

**Evidence of Implementation:** The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents’ needs. The preferred identifiers used for each resident were detailed within the residents’ clinical files. Each identifier was person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used prior to the provision of therapeutic services and programmes and the administration of medication.

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

**COMPLIANT**

**Quality Rating**

**Excellent**
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: 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. Approved centre menus were approved by a dietician to ensure nutritional adequacy in accordance with residents’ needs. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour and appearance. Hot and cold drinks were offered to residents on a regular basis. There was a source of safe, fresh drinking water available to residents in easily accessible locations throughout the approved centre.

The approved centre did not use an evidence based nutrition assessment tool, however nutritional and dietary needs were assessed when necessary and addressed in residents’ individual care plans. The needs of residents identified as having special nutrition requirements were regularly reviewed by a dietician. Weight charts were implemented, monitored and acted upon for residents, where appropriate. Intake and output charts were maintained for residents where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
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 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 not been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

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

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

The registered proprietor shall ensure that:

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

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

**INSPECTION FINDINGS**

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

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

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

**Evidence of Implementation:** The approved centre supported residents to keep and use their personal clothing. All resident clothing was clean and appropriate to the residents’ needs. Residents were provided with emergency personal clothing that was appropriate to the resident and considered their preference, dignity and bodily integrity. Residents changed out of night clothes unless specified otherwise in the individual care plan.

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

**COMPLIANT**

**Quality Rating**

Excellent
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Secure facilities were provided for the safe-keeping of the resident’s monies, valuables, personal property and possessions as necessary and each resident’s personal property and possessions was safeguarded when the approved centre assumed responsibility for them.

The resident was entitled to bring personal possessions with him or her - the extent of which was agreed with staff on admission. The approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This checklist was updated on an ongoing basis and was kept separate to the residents’ ICPs. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained. Residents were supported to manage their own property unless this posed a danger to the resident or others as indicated in their ICP in accordance with the approved centre policy.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in March 2018. The policy addressed requirements of the Judgement Support Framework, with the exception of the facilities available for recreational activities including the identification of suitable locations for the recreational activities within and external to the approved centre.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. The approved centre provided access to recreational activities on weekdays and during the weekend; however, the provision of weekend activities was dependent upon the availability of staff. Information about the activities 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 in the approved centre.

Recreational activity programmes were developed, implemented and maintained for residents with resident involvement. Individual risk assessments were completed for residents in relation to the selection of appropriate activities. Resident decisions on whether or not to participate in the activities were not documented. The approved centre provided residents with opportunities for indoor activities; residents had access to a gym which contained a treadmill, boxing bag, weights and an exercise bike. The lack of access to outdoor space meant that residents did not have opportunities for outdoor exercise. Communal areas were provided for recreational activities.

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Resident rights to practice religion were facilitated within the approved centre insofar as was practicable. There were facilities provided within the approved centre for religious practice and residents had access to multi-faith chaplains. Residents had access to local religious services and were supported to attend if deemed appropriate and following risk assessment. Care and services that were provided within the approved centre were respectful of the resident’s religious beliefs and values. Any specific religious requirements relating to the provision of services, care and treatment were clearly documented. Each resident was facilitated to observe or abstain from religious practice in accordance with his or her 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 in relation to visits. The policy was last reviewed in June 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Visiting times were publically displayed within the approved centre and these times were reasonable and appropriate. At the time of the inspection no residents had visitor restrictions in place. A separate visitors’ room was provided to accommodate residents wishing to meet with visitors in private. 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 visiting rooms were suitable for visiting children.

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 12: Communication

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to mail, fax, e-mail, internet and telephone unless otherwise risk-assessed with due regard to the residents’ well-being, safety and health. Individual risk assessments were completed for residents as deemed appropriate in relation to any risks associated with their external communication and documented in the individual care plan. At the time of inspection, no residents had any risks associated with their external communication. The clinical director or senior staff members only examined incoming communication if there was reasonable cause to believe that the communication may result in harm to the resident or others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in June 2018.

The policy addressed 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.

The policy did not address the process for communicating the approved centre’s search policy and procedures to residents and staff.’

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 not been completed to identify ways of improving search processes.

Evidence of Implementation: The resident search policy was communicated to all residents. A record of all searches that had taken place since the previous inspection was available and this included: the reason for the search and the names of staff member who undertook the search.
The file of a resident who had recently been searched was examined as part of the inspection process. Risk was assessed prior to the search of a resident. Resident consent was sought prior to searches taking place. The request for consent and the received consent were documented for the search of this resident as required. A minimum of two clinical staff were in attendance at all times while this search was being conducted. The resident was informed by those implementing the search about what was happening and why. The search was implemented with due regard to the resident’s dignity, privacy and gender.

Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
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 in relation to care of the dying. The policy was last reviewed in April 2018. The policy included all the requirements of the Judgement Support Framework with the exception of the process for ensuring that the approved centre is to be informed in the event of the death of a resident who has been transferred to another facility.

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 resident deaths within the approved centre since the previous inspection, this regulation was assessed solely on the basis of the processes and training pillars.

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

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

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

INSPECTION FINDINGS

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

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the 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: In total, 10 ICPs were reviewed as part of the inspection. Each of these care plans were a composite set of documents and was stored in the clinical file. All ICPs examined included an allocated space for goals, treatment, care and resources as well as space for review. The ICPs were identifiable and uninterrupted and were not amalgamated with progress notes. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address the immediate needs of the resident. The comprehensive assessment included: medical and psychiatric history, medication history and current medication, a current physical health assessment, a clinical risk assessment, social, interpersonal and physical environment issues. The residents’ communication abilities were not assessed as part of this assessment.

The ICP identified the residents’ assessed needs, appropriate goals and the care and treatment required to meet the goals identified including responsibilities for implementing care and treatment. The ICPs identified the resources required to ensure continuity in the implementation of the residents’ ICP. The ICPs included a risk management plan and a preliminary discharge plan where appropriate.

Not all ICPs were developed by the MDT within seven days of admission; one of the ten ICPs inspected was not put in place until 11 days after the residents’ admission. Not all ICPs were reviewed by the MDT team on a weekly basis. In nine cases the ICPs were reviewed and updated as indicated by the residents’ changing needs, condition, circumstances and goals. In one case the residents’ ICP was not reviewed within the weekly timeframe as would be expected for a resident with acute care needs.
Residents had access to their ICPs and were informed of any changes. In seven cases, resident involvement in the ICP process was documented. Resident involvement in the process was not documented in three ICPs inspected.

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

a) In one case, a care plan was not put in place for a resident within the required seven-day timeframe, 15.

b) In one case, the ICP was not reviewed within seven days as is required for a resident with acute needs, 15.
Regulation 16: Therapeutic Services and Programmes

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

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

**INSPECTION FINDINGS**

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

**Training and Education:** Not all clinical staff had signed the signature log to indicate that they had read and understood the 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 not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not 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 appropriate and met the assessed needs of the residents as documented in their individual care plans. The therapeutic services and programmes provided by the approved centre were evidence based. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. A list of therapeutic services and programmes provided in the approved centre was available to residents; residents had access to occupational therapists, psychologists, a speech and language therapist and social workers. Art therapy and music therapy were delivered in the approved centre.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved qualified health professional in an appropriate location. Adequate resources and facilities were available to provide therapeutic services and programmes which took place in a separate dedicated room that contained facilities and space for both individual and group therapies. A record was maintained of participation and engagement in therapeutic services in the residents’ individual care plans; this documentation also recorded the outcomes achieved.

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

**Regulation 18: Transfer of Residents**

**COMPLIANT**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A log of transfers was maintained. Each transfer record had 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 file of a resident who had been transferred to a general hospital was examined. 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 taking place; this included a discussion of the reasons for transfer, the residents’ care and treatment plan including needs and risks, and the resident’s accompaniment requirements on transfer.

Documented consent was received from the resident to the transfer. An assessment of the resident was completed prior to the transfer including an individual risk assessment. Full and complete written information for the resident was transferred as part of the transfer process. A resident transfer form was also completed in order to ensure that all information was sent with the resident.

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

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

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

**INSPECTION FINDINGS**

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

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

**Monitoring:** A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

**Evidence of Implementation:** The approved centre had an emergency trolley and staff had access to an AED at all times. Weekly checks were completed on the resuscitation trolley and on the AED. Records were available of a medical emergency within the approved centre and the care provided.

In total, five files were assessed as part of the inspection. All of these contained a general health check, however three of these general health checks had not been completed within the required 6 month timeframe.

An assessment of the five general health checks found that:

- Two general health checks did not include a record of family history.
- Three did not document resident weight, Body Mass Index or waist circumference.
- None of the files inspected contained a record of the residents’ smoking status.
- One of the files omitted nutritional status.
- One file was missing the resident dental check.

The files of three residents who were on antipsychotic medication were examined. One of the files did not include glucose regulation, blood lipids, an ECG or a test of prolactin levels.

There were adequate arrangements in place for residents to access general health services and for their referral to other health services. Residents could access national screening programmes that were...
available according to age and gender including: Breast Check, cervical screening, retina check and bowel screening. Residents had access to smoking cessation programmes and supports.

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

a) Three residents had not received a six monthly general health check within a timely manner, therefore the registered proprietor did not ensure that residents’ general health needs were assessed regularly 19,1 (b)

b) The general health checks of three residents were not completed in full, therefore the registered proprietor did not ensure that residents’ general health needs were assessed regularly 19,1 (b)

c) As the file one resident who was in receipt of anti-psychotic medication did not include an assessment of glucose regulation, blood lipids, an ECG or a prolactin test, the registered proprietor did not ensure that residents’ general health needs were assessed regularly 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 in relation to the provision of information to residents. The policy was last reviewed in May 2019. The policy included all of the requirements of the Judgement Support Framework with the exception of the information provided to residents on admission.

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

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

Evidence of Implementation: Required information was provided to residents and their representatives at admission; this included an information pack that detailed the care and services provided by the approved centre. This information pack was available in the required formats to support resident needs and was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies and resident rights. Residents were provided with details of their multi-disciplinary teams.

Residents were not provided with written and verbal information on diagnosis. Information was provided to residents on the likely adverse effects of treatment including risks and other potential side-effects. Medication information sheets were not consistently provided to residents. Residents had access to interpretation and translation services as required.

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

a) The registered proprietor did not ensure that suitable written information on the residents’ diagnosis was provided to residents 20, (1) (c)
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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 June 2018. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.
- The approved centre’s process for addressing a situation where resident’s privacy and dignity is not respected by staff.

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

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

Evidence of Implementation: Residents were called by their preferred name and the general demeanour of staff was respectful and conducive to maintaining resident privacy. Staff appearance and dress was also appropriate. Residents wore clothing that respected their privacy and dignity. When discussing the resident’s condition or treatment needs, staff discretion was used at all times. Staff sought resident permission before entering their rooms.

All bathrooms, showers, toilets and single bedrooms had locks on the inside of the door; these locks had an override function. Where residents shared a room or dormitory, bed screening ensured that their privacy was not compromised.

Blinds were fitted onto each window. However, in order to open or close them a special key was needed, which only the nursing staff had access to. Residents were not able to open and close the blinds in their bedrooms as and when they wished – they first had to request that nursing staff provide them with the special key to do so. While the majority of blinds in the approved centre remained closed, one blind on an internal window was broken leaving the inside of a dorm visible from a public area of the unit.

The ‘locked bedroom door policy’ within the approved centre meant that residents were opting to rest and sleep on couches in the public areas of the approved centre. Residents were lying on furniture and attempting to rest in communal spaces during the day. This practice was not conducive to maintaining resident privacy and dignity in the approved centre.
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 for the following reasons:

a) Residents were observed to be sleeping on couches in public areas of the approved centre due to the fact that their bedrooms were locked during the day. This was not conducive to maintaining resident’s privacy and dignity.

b) A blind on an internal window was broken, allowing visibility into a dormitory from the main area of the approved centre. This was not conducive to maintaining resident privacy.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in September 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed 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 not been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre provided access to personal space as well as appropriately sized communal rooms. Noise levels were minimised and the acoustics of the approved centre appeared appropriate. The lighting in communal rooms suited the needs of the residents; it facilitated reading and other activities. Appropriate signage and sensory aids were provided to support residents’ orientation needs. Sufficient spaces were provided to residents to move about, including outdoor space.

A cleaning schedule was implemented within the approved centre were provided for residents to move about, including outdoor space. Hazards, including large open spaces and stairs, slippery floors, hard and sharp edges and hard or rough surfaces were minimised within the approved centre. Ligature points remained a potential risk within the approved centre.

The approved centre was in a good state of repair at the time of the inspection. A number of maintenance issues were noticed by the inspection team on the first day and these were addressed prior to the last day of the inspection. There was a programme of general maintenance in the approved centre – this included...
decorative maintenance, cleaning, decontamination and repairs of assistive equipment. Nonetheless, the premises were observed to be unclean – particularly the fridge and the sink in the pantry within the POLL ward. One outdoor area contained litter such as cigarette butts and one toilet was observed to be malodorous. There was graffiti noted on the wall of the outdoor area next to the Psychiatry of Later Life area. The plant beds in all of the gardens were overgrown with weeds.

Where faults or problems were identified in relation to the premises this was reported through the appropriate maintenance process. Current national infection control guidelines were followed. Rooms were centrally heated, however the heating could not be controlled in the residents’ own room.

The approved centre provided suitable furnishings to support resident independence and comfort with the exception of the main sitting room which was bare and stark in appearance. This sitting room area on the main unit was sparsely decorated and did not have a homely feel. It was also a thoroughfare to the outdoor area where residents could smoke. The sitting room smelt of smoke as the adjoining door to the smoking area was often left open. The main sitting room of the approved centre was cold during the inspection.

There were sufficient numbers of toilets and showers for residents in the approved centre. Toilets were accessible and clearly marked and there were toilets located close to the day and dining areas. Wheelchair accessible toilet facilities were identified for use by visitors who required such facilities. The approved centre had a designated sluice room as well as designated cleaning and laundry rooms. Dedicated therapy and examination rooms were also available as appropriate. Remote and isolated areas of the approved centre were monitored. The approved centre provided assistive devices to address resident needs. Back-up power was available to the approved centre.

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

a) The registered proprietor did not ensure that the premises were clean and maintained in good decorative condition, 22 (1)(a). The following issues were noted in the outside areas:
   - The outdoor areas next to the Psychiatry of Later Life Unit was littered with cigarette butts on the pavement and plant bed areas.
   - A portion of the wall within the outdoor area next to the Psychiatry of Later Life unit displayed old graffiti.
   - The plant beds in all of the gardens were overgrown with weeds.

b) The registered proprietor did not ensure that the premises were clean and maintained in good decorative condition, 22 (1)(a). The following issues were noted inside the approved centre:
   - The fridge and sink in the pantry of the Psychiatry of Later Life Unit was not clean.
   - There was a malodorous smell in one of the male toilets on the main unit.
   - The smell of cigarette smoke was detected in the sitting room as the adjoining door to the smoking area was often left open.

c) The main sitting room was observed to be cold, meaning that the approved centre was not adequately heated 22, (1), b.

d) The registered proprietor did not ensure that the sitting room environment was developed and maintained with due regard to the specific needs and well-being of residents for the following reasons, 22(3):
   - The sitting room area on the main unit was sparsely decorated.
   - The sitting room acted as a thoroughfare to the outdoor area where residents could smoke.
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 June 2016. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had 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: A MPAR was maintained for each resident in the approved centre. In total, ten MPARs were examined and each was found to contain two appropriate resident identifiers, a record of allergies or sensitivities to medications, the generic name of the medication and dedicated space for both routine and once-off medications. The MPARs documented the frequency of administration and the dose or amount of the medication to be given. A record of all medications administered to the resident was maintained.

The medication prescription record included a clear record of the date of initiation for each medication and a clear record of the date of discontinuation. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was included within the record along with the prescriber signature. All of the records were legible and written in black ink. Medication was reviewed every six months at a minimum. Residents did not self-administer their medications. Medicinal products were administered in accordance with the 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 admission and good hand hygiene techniques were observed during the dispensing of medications. At the time of the inspection there were no Schedule 2 controlled drugs in the approved centre. Directions to crush medications were only accepted from the residents’ medical practitioner, however no current resident was receiving crushed medication.

Medication was stored in the appropriate environment as indicated on the label or packaging, and where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken.

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daily. Medication areas were clean and free from damp and mould. Medication storage areas were incorporated into the cleaning and housekeeping schedules. The medication trolley remained locked at all times. A system of stock rotation was in place within the approved centre. The approved centre had access to a pharmacist should the staff have medication related queries. The pharmacist visited the approved centre occasionally. The approved centre did not routinely complete a monthly inventory of their medication stock. All medications that were past their expiry were returned to the pharmacy.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in July 2018. It also had an associated safety statement, also dated July 2018. The policy and safety statement included all the requirements of the Judgment Support Framework.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre adopted the HSE Employee Handbook 2016-2017 in relation to staffing. The requirements of the Judgement Support Framework were met, including the following:

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

The policy did not address the following:

- The roles and responsibilities in relation to staffing processes.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The roles and responsibilities in relation to staff training processes.
- Orientation and induction training for all new staff.
- The ongoing staff training requirements and frequency of training needs to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

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

Evidence of Implementation: The approved centre had an organisational chart to identify the leadership and management structure as well as the lines of accountability for staff. A planned and actual staff rota was presented to the inspection team; this showed the staff on duty at any one time during the day and night. The numbers and skill mix of staff were sufficient to meet resident needs. Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment, selection and appointment. All staff were vetted in accordance with the approved centre’s staffing policies. Staff had appropriate qualifications to do their job and an appropriately qualified staff member was on duty and in charge at all times. The staffing plan for the approved centre was presented to the inspection team and it contained all of the elements required.

The required number of staff on duty at night ensured the safety of residents in the event of a fire or other emergency. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency.

Annual staff training plans were not completed for all staff to identify required training and skills development in line with the assessed needs of the resident groups. Not all healthcare professionals were trained in: Fire Safety, Basic Life Support, Management of violence and aggression, the Mental Health Act 2001.

Staff were trained in line with the assessed needs of the resident group profile including: manual handling, infection control and prevention, communicating with residents who have an intellectual disability, resident rights and recovery oriented approaches to mental health care. Orientation and induction training was completed for staff. Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff through tuition support, scheduled time away from work or recognition for the achievement. In-service training was completed by appropriately trained and competent individuals.

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>
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</tbody>
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*this data was not supplied to the inspection team

The following is a table of clinical staff assigned to the approved centre.

<table>
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<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
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<td>Unit 5B</td>
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<td>Regional on call</td>
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<td></td>
<td>CNM1 or 2</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>11 (+4 specials)</td>
<td>7 (+4 specials)</td>
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<tr>
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<td>Occupational Therapist</td>
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<tr>
<td></td>
<td>Social Worker</td>
<td>0</td>
<td></td>
</tr>
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<td></td>
<td>Psychologist</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activities Nurse</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

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

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

a) Not all staff were trained in Basic Life Support, Management of Violence and Aggression and Fire Safety

b) Not all staff were trained in the Mental Health Act, 2001
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 in relation to the maintenance of records. The policy was last reviewed in February 2018. The policy addressed the following aspects of the regulation:

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

The policy did not include the retention of inspection reports relating to food safety, fire inspections and health and safety.

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

Monitoring: Resident records were 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: All resident records were secure, up to date and constructed, maintained and used in accordance with national guidelines and legislative requirements. A record was initiated for every resident assessed and resident records were reflective of the residents’ current status and care and treatment being provided. Resident records were maintained using an identifier that was unique to the resident. Records were developed and maintained in a logical sequence.

Resident records were maintained appropriately. Entries were factual, consistent and did not contain jargon. Each entry included the date, however not every entry included a time using the 24-hour clock. Each entry was accompanied by a staff signature. All entries made by a student nurse or other clinical training staff were signed by a registered nurse or supervisor. Two appropriate resident identifiers were
recorded on all documentation. Records were appropriately secured throughout the approved centre from loss or destruction, tampering and unauthorised access or use. Records were destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

Resident records were accessible to authorised staff only, and only these staff made entries into the resident records. Staff had access to the data and information necessary to carry out their responsibilities. Residents’ access to their records was managed in accordance with the Data Protection Acts. Documentation of food safety, health and safety and fire inspection reports were maintained in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education and evidence of implementation pillars.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in November 2016.

It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to the development, management, and review of the operating policies and procedures.
- The process for the development of the operating policies and procedures required by the regulations, incorporating relevant legislation, evidence-based best practice, and clinical guidelines.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The process for making obsolete and retaining previous versions of operating policies and procedures.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all 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 not been undertaken to determine compliance with review time frames. Analysis had not 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 service users, as appropriate. The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame and incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The operating policies and procedures of the approved centre were appropriately approved. Policies and procedures were communicated to all relevant staff and an up to date policy was in place for each of the Regulations that required a policy.

The format of the policies and procedures was standardised and included:

- The title of the policy and procedure.
- A policy reference number.
- The document owner.
- Reviewers where applicable.
- The date at which the policy will be implemented.
- The scheduled review date.
- The total number of pages in the policy and procedure.

Neither the document approvers nor the scope of each policy and procedure were included in the standardised policy format.

Where generic policies were used the approved centre had a written statement to this effect which was reviewed every three years. Any generic policies were appropriate to the approved centre and the resident group profile.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, monitoring and evidence of implementation pillars.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided adequate resources and private facilities to support the Mental Health Tribunal process. Where required, staff were available to accompany and support patients in attending their Mental Health Tribunal should such assistance be 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 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints. The policy was based upon the HSE ‘Your Service, Your Say’ policy and was last reviewed in November 2017. The policy addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available to the approved centre. A consistent and standardized approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make complaints using the methods detailed in the complaints policy including: verbal, email, telephone and feedback form. The registered proprietor ensured access to advocates to facilitate the participation of the resident and their representative in the complaints process.

The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives.

This included:
• The provision of information about the complaints procedure to residents and their representatives at admission.
• The complaints procedure was publicly displayed and this included how to contact the nominated person.
• Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made.

All complaints, whether oral or written were investigated promptly and handled appropriately and sensitively. A method for addressing minor complaints within the approved centre was provided. Where minor complaints could not be addressed locally the nominated person dealt with the complaint. All complaints dealt with by the nominated complaints person were recorded in the complaints log. Details of these complaints were kept separate from the residents' ICP. Timeframes were provided for responding to the complainant following the initial receipt of the complaint, the investigation period for complaints and the required resolution of the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process was made available to them. The approved centre ensured that the quality of care provided to the resident who had made the complaint, was not adversely affected by reason of the complaint being made.

All information obtained through the course of the management of the complaint and the associated complaints 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 training and education and monitoring pillars.
Regulation 32: Risk Management Procedures

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had several written policies in relation to risk management and incident management procedures. These included the Safety Incident Management policy (last reviewed in 2015), the Serious Reportable Events HSE Guidance (last reviewed in 2015), the Addendum to the HSE Integrated Risk Management Policy and Supporting Guidance (last reviewed in 2017) and the Incident Management Framework for the Mental Health Division in the HSE Midwest Community Healthcare Organisation (last reviewed in 2018).

Combined, these policies addressed all of the requirements of the Judgement Support Framework, including the following:

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.
Monitoring: The risk register was not reviewed at least quarterly to determine compliance with the approved centre’s risk management policy; it was audited on a six monthly basis. 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: Responsibilities for risk management were allocated throughout the approved centre. The person with responsibility for risk within the approved centre was known to all staff. The risk management procedures did not actively reduce the risks to the lowest practicable level of risk, with the following risks observed on inspection:

- Risks associated with residents smoking on the premises were recorded and documented; this risk was particularly high at night time.
- The High Dependency Unit, with beds for eight residents, remained closed at the time of the inspection. This closure impacted upon the capacity of the remainder of the approved centre and impacted upon the risk management strategies used for residents.
- The approved centre continued to provide care to three service users who were inappropriately placed. As two of these residents were living in the Psychiatry of Later Life ward indefinitely, this section of the approved centre could not be utilised for its planned remit; to provide a separate five bedded section to facilitate the care of older aged residents. This posed a capacity risk for the approved centre.
- Observations on walkabout and the approved centre’s own ligature audit indicated that ligature risks remained within the approved centre. The policy of locking bedroom doors during the day went some way to mitigating these risks, however the risks remained outstanding at other times.

Clinical risks were identified, treated, reported and monitored within the approved centre and were documented in the risk register as appropriate. Individual risks assessments were completed prior to resident physical restraint. The approved centre did not use a standardised risk assessment tool on resident admission or at the time of discharge. Instead, risk was assessed as part of the nursing and medical admission and discharge assessments. Multi-disciplinary teams were involved in the development, implementation and review of the individual risk management process. The requirements for the protection of children and vulnerable adults within the approved centre was appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meetings. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The information provided was anonymous at resident level. There was an emergency plan that specified responses by the approved centre to possible emergencies.

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

a) The health and safety risk associated with the fact that resident smoking within the approved centre remained a risk was found to indicate that the service’s own risk management policy was not implemented throughout the approved centre, 32 (1).

b) The capacity risks associated with the continued inappropriate long term placement of three residents within the approved centre, coupled with the risks posed by the continued failure to open the High Dependency Unit indicated that the service’s own risk management policy was not implemented throughout the approved centre, 32 (1).
c) The ligature risks observed in the approved centre were not mitigated by the risk management strategy within the approved centre, 32 (1).
### 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 did not have an up-to-date certificate of registration with three conditions to registration attached. The first page of the certificate was displayed prominently at the entrance to the approved centre; however, the second page of the certificate of registration was not displayed at the time of the inspection.

The approved centre was non-compliant with this regulation because the approved centre’s certificate of registration was not displayed correctly at the time of the inspection.
EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

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 three written operational policies and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients which was last reviewed in March 2018. The policy addressed all policy-related criteria of this rule, including ECT protocols 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 delivering ECT were trained in line with best international practice and had appropriate training and education in basic life support techniques. All staff involved in delivering ECT attended the advanced cardiovascular life support course every two years.

Evidence of Implementation: The approved centre had a dedicated ECT suite, which included a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid response intervention area.

Material and equipment for ECT were in line with best international practice, and there was documentary evidence that ECT machines were regularly maintained. Materials and equipment in the ECT suite, including emergency drugs were in line with best international practice.

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant and named consultant anaesthetist had responsibility for ECT. There were 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 patient who was prescribed ECT was inspected. This indicated that the patient received appropriate information about the treatment, including details of likely adverse effects. The patient was also informed of their rights to an advocate and had the opportunity to raise questions at any time.

A written record of the assessments of capacity to consent to ECT was detailed in the patient’s clinical file. It indicated that the patient was unable to give informed consent for ECT. ECT was administered in
accordance with section 59(1)(b) of the Mental Health Act 2001. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed and placed in the clinical file, and a copy was sent to the Mental Health Commission within five days.

The programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file, which also contained a pre-anaesthetic assessment and an anaesthetic risk assessment. The consultant psychiatrist in consultation with the patient reviewed progress and the need for continuation of ECT.

The ECT record, which was completed after each treatment, was placed in the clinical files and the signature of the registered medical practitioners 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 ECT register was completed on conclusion of the ECT programme and a copy was placed in the patient’s clinical file.

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

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

**INSPCTION 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 each case there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment.

In two cases the patient was unable to consent to the continued receipt of medication and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed in each case. All of these forms contained the name of the medications being prescribed, the nature and purpose of the medication and the effects of the medication including possible side effects. There was also completed documentation of any views expressed by the patient in regards to the medication and any supports provided to the patient in relation to these discussions. In all cases authorisation by a second consultant psychiatrist was documented as required.

In one case, the patient had capacity to consent to medication. A detailed consent form outlining the names of the medications prescribed and a detailed discussion with the patient including the nature and
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.

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

It addressed the following:

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

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

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

Evidence of Implementation: Physical restraint was used in rare and exceptional circumstances within the approved centre and in these cases only after all alternative interventions to manage the residents’ unsafe behaviour had been considered. Any use of physical restraint was based upon risk assessment and cultural awareness and gender sensitivity were demonstrated at all times.

Three cases of physical restraint were reviewed as part of the inspection process. In all three cases, the physical restraint was initiated by a registered nurse or registered medical practitioner. A designated staff member was responsible for leading the physical restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and the registered medical practitioner completed a medical examination of the resident (physical examination) no later than three hours after the start of the episode of restraint. Each episode of physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A Clinical Practice Form was completed by the staff member initiating and ordering physical restraint within the required 3 hour timeframe; this form was signed by the consultant psychiatrist within 24 hours. A copy of the clinical practice form was placed in each of the files as required.

In all three episodes of physical restraint, the resident was informed of the reasons for, likely duration of and circumstances that would lead to the discontinuation of physical restraint. Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after each episode. All residents discussed the episode of restraint with members of their MDT as soon as was practicable.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in February 2017. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: Three children had been admitted to the approved centre since the last inspection. As Unit 5B Limerick was an adult approved centre, age-appropriate facilities and a programme of activities appropriate to children were not provided. Provisions were in place to ensure the safety of the child and respond to child’s special needs as a young person in an adult setting. Provisions were made to ensure the right of the child to have their views heard while resident in the approved centre. The inspection team were informed that education arrangements were available if required, however access to education was not required for any of the three children admitted.

Children did not have access to child advocacy services. Consent for treatment was obtained from one or both parents. Appropriate visiting arrangements and accommodation was provided, with children assigned single rooms with private bathroom facilities. Observation arrangements, including assignment of a designated staff member, was provided as considered clinically appropriate and acknowledged gender sensitivity.

Advice from the Child and Adolescent Mental Health Service was available. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. The approved centre had notified the Mental Health Commission of all child admissions with the required 72 hour timeframe. Staff had undergone Garda vetting.

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

a) Age-appropriate facilities and a programme of activities were not provided by the approved centre, 2.5 (b).

b) Child residents did not have access to child advocacy services, 2.5 (g).
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 three written policies in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients last reviewed in March 2018. The policy addressed all policy-related criteria of this code of practice, including ECT protocols 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 delivering ECT were trained in line with best international practice and had appropriate training and education 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. Material and equipment required for ECT, including emergency drugs, were in line with best international practice. The ECT machine was 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. A registered designated ECT nurses was in the ECT suite at all times.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient’s capacity to consent to receiving treatment, and this was documented in the patient’s clinical file. The patient was deemed capable of consenting to the receipt of ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the patient 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 each patient could understand. The patient 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. The consultant psychiatrist administered a capacity assessment on the voluntary patient.

A programme of ECT for the voluntary patient 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 voluntary patient and 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.

The ECT record, which was completed after each treatment, was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. All pre and post ECT
assessments were detailed and recorded in the clinical file. The reasons for continuing or discontinuing ECT was recorded. 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 a written policy in relation to admission, transfer, and discharge.

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

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

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

Monitoring: Audits had not been completed on the implementation of and adherence to the admission, transfer and discharge policy.

Evidence of Implementation:

Admission: The approved centre had a key worker system in place. The admission of one resident was examined and this admission was on the basis of a mental disorder or mental illness. An admission assessment had been completed; this assessment included documentation of the presenting problem, past psychiatric history, medical history and a full physical examination. The assessment did not include family history or a risk assessment.

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

Discharge: The discharge process pertaining to one resident was examined as part of the inspection process. A discharge plan had been completed for the resident and this included; documented communication with the relevant General Practitioner or Community Mental Health Team, a follow up plan and a reference to early warning signs of relapse. A discharge meeting was attended by the resident, the key worker and the relevant members of the MDT prior to discharge. A discharge assessment was completed prior to resident discharge and a preliminary summary was sent to the GP or CMHT within three days. A comprehensive discharge summary was issued within 14 days. This summary included: resident diagnosis, prognosis mental state at discharge and outstanding social or health issues. This summary did not contain risk issues such as signs of relapse. A family member was involved in the discharge process as appropriate.

The approved centre was non-compliant with this code of practice for the following reasons:
a) The approved centre had not conducted audits on the admission, transfer and discharge processes, 9.1.
b) The admission assessment did not include family history or a risk assessment, 15.3.
c) The discharge summary issued to the residents’ GP or Community Mental Health Team did not contain reference to risk issues for the resident, 38.4.
## Regulation 19: General Health

**Reason ID : 10000605**

Three residents had not received a six monthly general health check within a timely manner, therefore the registered proprietor did not ensure that residents’ general health needs were assessed regularly 19.1 (b)

<table>
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<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
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<tbody>
<tr>
<td>Email issued by Clinical Director to all doctors regarding the necessity to complete 6 monthly general health checks. General Health will become a standing item in the Consultant Business Meetings. A general health care audit will be introduced and conducted quarterly to capture compliance.</td>
<td>General Health Audit will be conducted quarterly. Minutes of Consultants meetings. General Health Audit will be conducted quarterly.</td>
<td>All actions Achievable</td>
<td>13/01/2020</td>
<td>Dr. Servaiase Winkel Clinical Director Sinead Ryan-Cook, Assistant Director of Nursing Lorraine Naughton, Clinical Nurse Manager III</td>
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<tr>
<td>Clinical Director has highlighted to all NCHDs the required checks as outlined in the Junior Doctors Hand Book which is discussed at every NCHD Induction. There is a robust discussed at ICP MDT meeting in advance. General Health Audit will be conducted quarterly There is a robust flagging system of service users due their six monthly checks sent</td>
<td>Discussed at ICP MDT meeting in advance. General Health Audit will be conducted quarterly.</td>
<td>Achievable</td>
<td>13/01/2020</td>
<td>Dr. Servaiase Winkel Clinical Director Sinead Ryan-Cook, Assistant Director of Nursing Lorraine Naughton, Clinical Nurse Manager III Lisa O'Grady, Administration</td>
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flagging system of service users due to their six monthly checks sent out to the Consultants and Nurse Managers. There is a list of general health review dates for service users in the nursing office. A general health care audit will be introduced and conducted to capture compliance.

<table>
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<tr>
<th>Reason ID</th>
<th>The general health checks of three residents were not completed in full, therefore the registered proprietor did not ensure that residents' general health needs were assessed regularly 19.1 (b)</th>
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<tbody>
<tr>
<td>Corrective Action</td>
<td>Email issued by Clinical Director to all Doctors regarding the necessity to complete 6 monthly General Health Checks. General Health will become a standing item in the Consultant Business meetings. A general health care audit will be introduced and conducted quarterly. General Health Audit will be conducted quarterly. Minutes of Consultants meetings. General Health Audit will be conducted quarterly.</td>
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<td></td>
<td>Achievable</td>
<td>13/01/2020</td>
<td>Dr. Servaise Winkel Clinical Director Sinead Ryan-Cook, Assistant Director of Nursing</td>
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</table>
Preventative Action

CD has highlighted to all NCHD's the regular checks as outlined in the Junior Doctor Hand Book. There is a robust flagging system of service users due their six monthly checks sent out to the Consultants and Nurse Managers. There is a list of general health review dates for service users in the nursing office. General health audit will be conducted quarterly.

General health audit will be conducted quarterly. Achievable 13/01/2020 Dr. Servaise Winkel, Clinical Director Lisa O'Grady, Administration

Reason ID: 1000607

As the file one resident who was in receipt of anti-psychotic medication did not include an assessment of glucose regulation, blood lipids, an ECG or a prolactin test, the registered proprietor did not ensure that residents' general health needs were assessed regularly 19,1 (b)

Corrective Action

Email issued by Clinical Director to all Doctors regarding the necessity to carry out General health Assessments on each resident. General Health will become a standing item in the Consultant Business. General health audit will be conducted quarterly. Minutes of Consultant Meetings Achievable 13/01/2020 Dr. Serviase Winkel CD Sinead Ryan-Cook
Meetings. A General Health Care Audit will be introduced and conducted quarterly to capture compliance.

Preventative Action

CD has highlighted to all NCHDs the required checks as outlined in the Junior Doctors Hand Book. There is a robust flagging system of service users due their six monthly checks sent out to the Consultants and Nurse Managers. There is a list of general health review dates for service users in the nurse’s office A general health care audit will be introduced and conducted to capture compliance.

<p>| Preventative Action | General health audit to be conducted quarterly. There is a robust flagging system of service users due their six monthly checks sent out to the Consultants and Nurse Managers. There is a list of general health review dates for service users in the nurses’ office. | Achievable. | 13/01/2020 | Dr. Servaise Winkel, Clinical Director Lisa O’Grady, Administration Lorraine Naughton, CNM3 Sinead Ryan-Cook |</p>
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<tr>
<td>The CD had advised all doctors by email of the importance of providing written information on the diagnosis and medication to each resident. The Health Product regulatory authority website will be available on the computers in the approved centre which provides up to date information on medication. Up to date information regarding diagnosis will be readily available in the approved centre and offered to the resident.</td>
<td>The provision of the website will be discussed at the weekly nurses meetings and monthly Consultant meetings. Up to date information leaflets will be available in the Approved Centre and compliance will be monitored and improvements captured during analysis and during the community meetings.</td>
<td>Achievable</td>
<td>31/01/2020</td>
<td>Dr. Servaise Winkel. Clinical Director Sinead Ryan-Cook, Assistant Director of Nursing Lorraine Naughton, CNM3</td>
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<th>Post-Holder(s)</th>
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<tbody>
<tr>
<td>Email issued to all doctors by CD regarding the necessity to consult with the Junior Doctors Hand Book.</td>
<td>The provision of the website will be discussed at the weekly nursing meetings and monthly Consultant meetings.</td>
<td>Achievable</td>
<td>31/03/2020</td>
<td>Dr. Servaise Winkel Clinical Director Lorraine Naughton, Clinical Nursing Manager III Sinead</td>
<td></td>
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</tbody>
</table>
The Clinical Director had advised all doctors by email of the importance of providing written information on the diagnosis and medication to each resident. The Health Product regulatory authority website will be available on the computers in the Approved Centre which provides up to date information on medication.

Reason ID: 10000611

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<tr>
<td>An information folder on common medications has been developed and is available to all residents in the group room. Residents have access to the internet under a generic login username and password. Information is also provided by the</td>
<td>Ongoing and updated as required.</td>
<td>Ongoing</td>
<td>06/12/2019</td>
<td>Dr. Servaise Winkel, CD &amp; all Responsible Consultant Psychiatrists and Nursing Staff. Nora Mullane, ADON Staff allocated to Therapeutic Programme</td>
<td></td>
</tr>
</tbody>
</table>

Ryan-Cook, Assistant Director of Nursing
| Preventative Action | An information folder on common medications has been developed and is available to all residents in the group room. Residents have access to the internet under a generic login username and password. Information is also provided by the Responsible Consultant Psychiatrist and Nursing Staff. | Ongoing and updated as required. | Ongoing | 06/12/2019 | Dr. Servaise Winkel, CD & all Responsible Consultant Psychiatrists and Nursing Staff. Nora Mullane, ADON Staff allocated to Therapeutic Programme |
### Regulation 21: Privacy

**Reason ID: 10000620**

Residents were observed to be sleeping on couches in public areas of the approved centre due to the fact that their bedrooms were locked during the day. This was not conducive to maintaining resident privacy and dignity.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Lock Door policy is under review at present and awaiting the outcome of this review.</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>09/12/2019</td>
<td>CPPPG Committee, Mid West Area Management Team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Ongoing</td>
<td>09/12/2019</td>
<td>CPPPG Committee, Mid West Area Management Team</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
<td>Time-bound</td>
<td>Post-Holder(s)</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>Corrective Action</td>
<td>There is an ongoing Training Programme within the service. There are staff now trained within the Mental Health Services in BLS and also a programme of delivery within the nursing service. There is an ongoing training programme for PMAV and to date there is 95% compliance in both areas for Nursing. There is a fire training schedule in place for all disciplines.</td>
<td>Ongoing Nursing training records update quarterly and staff are allocated staff training dates to ensure compliance.</td>
<td>Ongoing</td>
<td>06/12/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>There is an ongoing Training Programme within the service. There are staff now trained within the Mid West Mental Health Services in BLS and there is a programme of delivery within the service. There is an</td>
<td>Ongoing Nursing training records update quarterly and staff are allocated staff training dates to ensure compliance.</td>
<td>Updated as required</td>
<td>06/12/2019</td>
</tr>
</tbody>
</table>
ongoing training programme for PMAV and to date there is 95% compliance in both areas. There is a fire training schedule in place.

<table>
<thead>
<tr>
<th>Reason ID : 10000617</th>
<th>Not all staff were trained in the Mental Health Act, 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specific</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>There is an ongoing training programme for MHA 2001 via HSELand for all staff</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>There is an ongoing training programme for MHA 2001 via HSELand for all staff</td>
</tr>
</tbody>
</table>
### Regulation 34: Certificate of Registration

<table>
<thead>
<tr>
<th>Reason ID: 10000601</th>
<th>The approved centre's certificate of registration was not displayed correctly at the time of the inspection.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specific</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>It is now on display in Reception of Unit 5B</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Complete</td>
</tr>
</tbody>
</table>
### COP Relating to Admission of Children under the Mental Health Act 2001.

**Reason ID:** 10000608

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It has been agreed that a range of activities that a young person can engage in while on this Unit will be assessed and agreed on admission and will form part of the ICP and will be reviewed accordingly. Due regard will be paid to the issues of risk, child protection, consent, suitability and contact with adult service users in identifying activities for these service users. Opportunities to spend time off the Unit will also be actively assessed as part of the ICP.</td>
<td>Case review meetings to incorporate a review of the activities provided and available for the young person during the period of admission. All activities agreed and carried through to be documented on clinical record</td>
<td>This is an Adult Acute Admission Unit and as such is not structured or resourced to provide separate and/or specifically age appropriate facilities for activities. This will limit the options and opportunities in terms of the range and frequency of in-house activities particularly.</td>
<td>11/12/2019</td>
<td>Unit Nurse Managers to implement and monitor and CAMHS staff working with the child and Unit staff, 'Special' Nurse and all other relevant Unit staff to implement.</td>
</tr>
</tbody>
</table>

| Preventative Action | This issue arises in the context of the admission of children to an age inappropriate care setting which in turn ICP and Clinical notes to reflect implementation of Corrective actions | The number and range of activities available is limited by the age inappropriate setting | 11/12/2019 | Unit Nurse Managers to implement and monitor and CAMHS staff working with the child and Unit staff, 'Special' Nurse |
arises from limitations in access to age appropriate facilities as they arise. Ensure when admission of a child occurs that the actions agreed above are followed through and all other relevant Unit staff to implement.

<table>
<thead>
<tr>
<th>Reason ID : 10000609</th>
<th>Child residents did not have access to child advocacy services, 2.5 (g).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Corrective Action</td>
<td>CAMHS Nursing staff have produced a service user information leaflet for young people (and their parents/carers) admitted to this Unit. The process involved consultation with Unit Nursing staff and input from the Service User Forum through the Local Lead for Service User Engagement. In relation to advocacy services for young people admitted to Approved Centres the Irish Advocacy Network (IAN) are in the process of</td>
</tr>
</tbody>
</table>
establishing a service for young people admitted to in-patient care. While it is not yet fully in place contact details for an advocacy worker who will be available to young people admitted to this Unit and their parents/carers have been accessed and are included in the service user information leaflet. Key nurse on Unit will continue to use the Headspace Toolkit on admission and to support and engage with the young person and parents/carers around ensuring that the information provided is understood. The information leaflet provides information on the rights of the young person and the parent/carer in respect of their engagement with this
<p>| Preventative Action | Information provision and orientation on admission to ensure this information is provided to young person and parent/carer. CAMHS and Unit staff involved in the care of the young person to facilitate any requests for access to Advocacy services | Document on Case file | Information Booklet attached. | 11/12/2019 | Unit Nurse Managers to implement and monitor and CAMHS staff working with the child and Unit staff, Key nurse on the Unit, 'Special' Nurse and all other relevant Unit staff to implement. |</p>
<table>
<thead>
<tr>
<th>Reason ID : 10000602</th>
<th>The admission assessment did not include family history or a risk assessment, 15.3.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Section 8 of the current Mid West Adult Mental Health Assessment Form includes a section for family history which includes (number of sibling, place in the family, details of parents, parental occupation, quality of parental and sibling relationship, significant death, family history of mental health or physical illness / alcoholism / drug use). The Mid West Adult Mental Health Assessment Form is considered to be a risk assessment and Section 18 of this assessment includes a summary of risk issues. Where patient is too unwell or unwilling to give said information with</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Section 8 of the current Mid West Adult Mental Health Assessment Form includes a section for family history which includes (number of sibling, place in the family, details of parents, parental occupation, quality of parental and sibling relationship, significant death, family history of mental health or physical illness / alcoholism / drug use).</td>
<td>Mid West Adult Mental Health Assessment Form</td>
</tr>
</tbody>
</table>
regard to this should be documented.

Preventative Action
Mental Health Assessment Form is being currently reviewed.

Preventative Action

Complete
Complete
06/12/2019
Medical Records Committee Dr. Servaise Winkel, CD Ms. Nora Mullane, ADON

Reason ID : 10000603
The approved centre had not conducted audits on the admission, transfer and discharge processes, 9.1.

Corrective Action
Audits are being completed through Best Practice Guidelines

Ongoing
Ongoing, audits to be completed quarterly
06/12/2019
Best Practice Guidelines Committee

Preventative Action
Ongoing audits to be completed quarterly by Best Practice Guidelines Committee

Ongoing
audits to be completed quarterly by Best Practice Guidelines Committee
06/12/2019
Best Practice Guidelines Committee

Reason ID : 10000604
The discharge summary issued to the residents' GP or Community Mental Health Team did not contain reference to risk issues for the resident, 38.4.

Corrective Action
In the comprehensive Discharge Summary, it includes a section relating to "Reason for Admission" "Findings on Admission" and "Conditional on Discharge" and Prognosis and Recommendations" It

Ongoing
Training for NCHD’s to ensure that a discharge summary is completed on each resident outlining relevant risks.
06/12/2019
Dr. Servaise Winkel, CD and all Responsible Consultants Psychiatrists
| Preventative Action | In the comprehensive discharge summary it includes a section relating to "Reason for Admission" "Findings on Admission" and "Conditional on Discharge" and Prognosis and Recommendations" It also includes a follow-up appointment time and date | Ongoing | Training for NCHD’s to ensure that a discharge summary is completed on each resident, outlining risks issues. | 06/12/2019 | Dr. Servaise Winkel, CD and all Responsible Consultants Psychiatrists |
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.