Le Brun House & Whitethorn House, Vergemount Mental Health Facility

ID Number: AC0095

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Le Brun House & Whitethorn House, Vergemount Mental Health Facility
Clonskeagh Hospital
Clonskeagh
Dublin 6

Conditions Attached: Yes

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

Registered Proprietor: HSE

Most Recent Registration Date: 9 February 2018

Registered Proprietor Nominee: Ms Martina Behan, General Manager, CHO East Mental Health Services

Inspection Team:
Marianne Griffiths Lead Inspector
Martin McMenamin
Carol Brennan Forsyth

Inspection Date: 10 – 12 April 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 3 – 6 December 2018

Date of Publication: Tuesday 17 September 2019

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

2019 COMPLIANCE RATINGS

- REGULATIONS: 3 Compliant, 5 Non-compliant, 5 Not applicable
- RULES AND PART 4 OF THE MENTAL HEALTH: 4 Compliant, 3 Non-compliant, 4 Not applicable
- CODES OF PRACTICE: 1 Compliant, 3 Non-compliant, 3 Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

1.0 Inspector of Mental Health Services – Review of Findings ................................................. 4

2.0 Quality Initiatives .......................................................................................................................... 7

3.0 Overview of the Approved Centre .................................................................................................. 8

3.1 Description of approved centre ..................................................................................................... 8

3.2 Governance .................................................................................................................................... 8

3.3 Reporting on the National Clinical Guidelines ............................................................................ 9

4.0 Compliance ..................................................................................................................................... 10

4.1 Non-compliant areas on this inspection ....................................................................................... 10

4.2 Areas of compliance rated “excellent” on this inspection ............................................................ 10

4.3 Areas that were not applicable on this inspection ....................................................................... 11

5.0 Service-user Experience ................................................................................................................. 12

6.0 Feedback Meeting .......................................................................................................................... 13

7.0 Inspection Findings – Regulations ................................................................................................ 14

8.0 Inspection Findings – Rules ......................................................................................................... 53

9.0 Inspection Findings – Mental Health Act 2001 .......................................................................... 54

10.0 Inspection Findings – Codes of Practice ..................................................................................... 55

Appendix 1: Corrective and Preventative Action Plan ...................................................................... 57

Appendix 2: Background to the inspection process .......................................................................... 67
In brief

The approved centre was part of HSE Community Healthcare East (formerly CHO 6). It was located within the grounds of Clonskeagh Hospital and consisted of Whitethorn unit, which provided the continuing care of adults with enduring mental health needs under the General Adult team, and Le Brun unit, which came under the Psychiatry of Later Life services. The hospital campus incorporated a variety of healthcare facilities.

The approved centre did not demonstrate improvement in overall compliance with regulations, rules and codes of practice, with 79% compliance on this inspection, 86% compliance in 2018, and 75% compliance in 2017. Eight compliances with regulations were rated excellent compared to eleven in 2018.

Conditions to registration

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

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

*Finding on this inspection:* The approved centre was in breach of Condition 1, as it remained non-compliant with Regulation 22: Premises, at the time of inspection. A programme of decorative maintenance was underway in Whitethorn unit along with remedial works to address ligature risks.

Safety in the approved centre

- Appropriate identification processes were in place to safeguard residents during the provision of care.
- Regular food safety audits were undertaken.
- Medication management processes were satisfactory.

However:

- A hygiene audit had not been undertaken.
- Despite a significant improvement in staff training, not all staff had received training in the Mental Health Act 2001.
- Garden areas required on-going maintenance to ensure that trip hazards were minimised.
Appropriate care and treatment of residents

- All residents had an individual care plan which was up to date. Residents had access to their care plans and, where appropriate, development and review of the care plan involved family or other supports.
- Appropriate supports were provided to residents and families during end of life care.

However:

- Residents had limited access to psychology and social work support and, at the time of this inspection, there was no occupational therapy input to the approved centre. Due to the limited resources available, the therapeutic services and programmes provided did not meet the appropriate needs of residents.
- Physical health reviews continued to fail to meet the minimum requirements, posing a potential risk to the on-going well-being of residents.

Respect for residents’ privacy, dignity and autonomy

- Residents were supported to manage their own clothing and property where they had the capacity to do so.
- Facilities were available for residents to meet with visitors in private.
- Residents were free to communicate with anyone they wished.
- Staff were respectful of residents’ privacy and dignity in their interactions.
- The approved centre was clean, hygienic, and free from offensive odours.

However:

- The outer doors of the approved were locked and residents had to request to enter or leave.
- The approved centre was not in a good state of repair internally. Various maintenance works had not been commenced or was left unfinished. Scuffed paintwork was noted on walls and architraves. Skimed plaster areas had not been painted. Repair work was unfinished or not commenced; there were broken call bells, skirting lino separating from the wall, and older style sink units in poor repair. Two dormitories had extra beds stored in them, and the floor covering throughout Whitethorn unit was old, mismatched, torn, and in need of replacement. Le Brun unit was in need of repainting and minor decorative repairs.

Responsiveness to residents’ needs

- Residents had access to adequately sized interior and external communal spaces.
- An appropriate range of recreational activities was available to residents.
- Residents, and their families, were provided with information regarding the operation of the approved centre including, where appropriate, information on diagnosis and medication effects.
Governance of the approved centre

- The approved centre was part of Community Healthcare East (formerly CHO6).
- The service fostered a culture of risk assessment and management and it was evidenced that staff across the disciplines had training and specific expertise in these areas.
- Area Quality and Safety meetings, involving the approved centre, took place every two months and considered a variety of quality and risk issues pertinent to the approved centre.
- The risk register for the approved centre was reviewed and updated on a quarterly basis.

However:

- The lack of a Rehabilitation and Recovery team with associated staffing deficits, particularly in the area of occupational therapy, has not yet been addressed through the service governance processes, with detrimental therapeutic effect on residents.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The ‘Hello, my name is’ quality initiative had been introduced since the 2018 inspection. All staff wore badges that stated ‘Hello, my name is...’ in order to encourage residents to approach them and speak with them.

2. The personal property rooms in Whitethorn and Le Brun had been developed to allocate an individual locker to each resident. This provided access to extra room to safety store their belongings over and above the storage space in their bedrooms.

3. Painting and decorating of Whitethorn unit had commenced at the time of inspection and the appearance of this unit had been improved since the 2018 inspection.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within the grounds of Clonskeagh Hospital near the South Dublin village of Ranelagh. Various other health care facilities were also located within the Clonskeagh Hospital campus as well as a small chapel which residents could access. The approved centre consisted of Whitethorn unit, which provided the continuing care of adults with enduring mental health needs under the General Adult team, and Le Brun unit, which came under the Psychiatry of Later Life services. At the time of the inspection, Whitethorn unit was being painted in order to brighten up its interior. Both units consisted of many small rooms connected by narrow corridors. In both cases, the gardens required some attention including the removal of old furnishings and some trip hazards. Entry to Le Brun required a swipe card, an access code and the key to a locked internal door. To gain access to Whitethorn staff used a swipe card and a code; at the time of the inspection, no resident had access to these and had to request staff assistance to exit or enter the building. All residents were voluntary at the time of the inspection.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>34</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>32</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>4</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>31</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The approved centre was part of Community Health Organisation 6. A culture of incident reporting and risk management was fostered within the Dublin South East Mental Health Services, including the approved centre. Staff from all disciplines had high levels of training in risk identification and assessment. While governance arrangements for Dublin South East (DSE) were generally defined, the inspection team had difficulty in establishing how occupational therapy governance responsibility was structured. The absence of a Rehabilitation and Recovery team in the Dublin South East area coupled with the occupational therapy (OT) staffing deficits within DSE, had implications for the provision of OT services to residents in Whitethorn.

Each of the Heads of Discipline for Nursing, Medical, Social Work, Occupational Therapy and Psychology completed the Mental Health Commission Governance questionnaire. Responses from these questionnaires indicated that staffing was the biggest risk faced by each department. The difficulties around occupational therapy staffing had been escalated to the area risk register. There was a strong culture of supervision and appraisal in each of the departments, although this had not been formalised for nursing staff.
Area Quality and Patient Safety meetings took place on a two monthly basis. Issues discussed at these meetings included a reviews of the overall incident reports, discussion of quality improvement plans, and the updating of the risk register. The area executive management team met on a monthly basis to discuss challenges faced by the service and review upcoming plans and initiatives.

### 3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
<td>√</td>
<td>√</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</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 Low</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

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

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

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

With the residents’ permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents’ experience of the approved centre as outlined below. In total, five residents gave feedback to the inspection team about their experiences of the approved centre. Resident feedback was positive and was complimentary of the food and the care provided by the nursing staff. One resident commented that the availability of more activities during the day would be welcomed. The residents welcomed the fact that Whitethorn was in the process of being decorated. Feedback from one resident indicated a level of anxiety pertaining to the plans for the unit including a possible move. Staff were informed about this query and the correct information was subsequently provided to the resident in order to offer reassurance that any moves from the approved centre would be clearly explained and planned prior to their implementation. No resident completed the service user questionnaire to the inspection team.
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
- Consultant Psychiatrist
- Head of Service
- Area Director of Nursing
- Occupational Therapy Manager
- Clinical Nurse Manager 3
- Quality and Safety Adviser
- Clinical Nurse Specialist – Activities
- CNM2
- Principal Social Worker
- Assistant Director of Nursing

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The management team explained the plans for the unit including the anticipated relocation of older aged residents from a nearby 24-hour residence into the approved centre. The transition of the residents under the General Adult Psychiatry team in Whitethorn into a less restrictive environment was also discussed. Clarifications were sought with respect to the evidence base used to create the approved centre ligature audit tool, the process for maintaining the grounds of the approved centre, and the process for the auditing of complaints data by the approved centre.
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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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, appropriate to the resident group profile. Identifiers including resident photograph, name, date of birth, and hospital number were used. This was in line with individual residents’ needs. Identifiers were person-specific, and did not include room number or physical location. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services.

An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or a similar name; an alert sticker system was in place. These stickers were yellow in colour were placed on the clinical file and Medication Prescription Administration Record’s (MPARs) to highlight similar named residents.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 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 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 and nutrition, as set out in the policy.

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

Evidence of Implementation: Residents in the approved centre were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. In addition, residents had at least two choices for meals. There were water coolers throughout the approved centre, ensuring a source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: There was suitable and sufficient catering equipment in the approved centre, as demonstrated through staff interview and observation. In addition, there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Cleaning schedules were in place, and food was generally prepared in the main hospital kitchen. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: All resident laundry was washed and dried in the laundry room in Whitethorn. Each resident had their own linen basket with their name on it. The approved centre ensured that personal clothing was appropriate and took into account residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents were in their day clothes during the day unless being nursed in bed or otherwise specified in their individual care plans. Residents had a plentiful supply of their own clothing and there was a stock of new clothing and emergency available when it was 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 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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents’ personal property and possessions were safeguarded; they were locked away in secure facilities when the approved centre assumed responsibility for them. Each resident had a secure personalised locker, located in a locked room, for items such as passports and post office books. The access to and use of resident monies was overseen by two members of staff. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained.

The resident was entitled to bring personal possessions with him or her, the extent of which was agreed at admission. However, the resident and their family were encouraged to retain as many personal items as possible at home, if appropriate. 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. Residents were supported to manage their own money unless this posed a danger to the resident or others as indicated by their individual care plan.

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile, including trips away two to three times a year. Access was provided to recreational activities on weekdays and during the weekend. Activity programmes were discussed at community meetings in Whitethorn. These were based on meaningful activities assessments and Pool Activity Level Assessment (PAL) in Le Brun unit. Recreational activities available in the approved centre included newspaper reviews, DVDs, dog therapy, movies and TV, hand massage, relaxation and various annual trips away for the residents. A static pedal machine was used to aid resident mobility under the supervision of the physiotherapist. Residents had full access to the garden in Whitethorn and supervised access in Le Brun.

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. Facilities were provided in the vicinity of the approved centre for residents’ religious practices, as a mosque was in the proximity, and there was a chapel on the hospital grounds.

Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. The residents were 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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 in the approved centre were appropriate and reasonable. A separate visitors’ room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Additionally, children visiting were accompanied at all times to ensure their safety. This was communicated to all individuals publicly. The approved centre visiting area was 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

COMPLIANT

Quality Rating
Excellent

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to mail, 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 ICP. Senior staff only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in April 2017. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: A log of searches was maintained.

Evidence of Implementation: As no searches had been conducted since the last inspection, the evidence of implementation pillar was not applicable.

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. This was documented in the resident’s ICP. There had been two deaths since the 2018 inspection. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of residents were protected. Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

Staff had not consistently received the required support following the death of a long-term resident. More support to and improved communication with staff by the approved centre would have been appropriate following the death of a resident in the approved centre.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.
Regulation 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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: ICPs were developed by the MDT following a comprehensive assessment, within seven days of admission. ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. ICPs identified the resources required to provide the care and treatment identified. ICPs were reviewed by the MDT in consultation with the resident on a six-monthly basis in both units. When appropriate, the resident had access to the ICP and was kept informed of any changes. Residents were offered a copy of their ICP, including any reviews, and this was documented. In the event of a resident declining or refusing a copy of their ICP, this was recorded.

ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. A key worker was not identified to ensure continuity in the implementation of a resident’s ICP. The ICP did not include an individual risk management plan.

The approved centre was non-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 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 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The range of services and programmes provided in the approved centre 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 not appropriate and did not meet the assessed needs of the residents as documented in their care plans. While one-to-one psychology and social work services were available to residents on a referral basis from the multi-disciplinary team, there was no occupational therapist on the General Adult Psychiatry team. Similarly, there was no occupational therapist allocated to the approved centre. Some nurse-led therapeutic programmes were in place in the approved centre including SONAS, mindfulness relaxation and Simple Therapeutic Activities for Residents.

These therapies were evidence-based and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of these therapeutic services was provided to the residents; again, this list comprised solely of nurse-led therapeutic services. Adequate and appropriate resources were not available to provide therapeutic services in the approved centre. Therapeutic services provided took place in the recreational room. There was no occupational therapy kitchen or activities of daily living room within the approved centre. A record was maintained of participation and engagement in the outcomes achieved in nurse led therapeutic services and one to one psychology or social work input.

The approved centre was non-compliant with this regulation the lack of occupational therapy input into the approved centre meant that residents did not have access to an appropriate range of therapeutic services, 16 (1).
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in October 2017. The policy addressed requirements of the Judgement Support Framework, with the exception of the process for managing resident property during the transfer process.

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

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

Evidence of Implementation: Residents being transferred were accompanied by a nurse on transfer. Documented consent of a resident to transfer was available or justification as to why consent was not received. This was evident in the clinical file. An individual risk assessment relating to the transfer and the resident’s needs was completed for the resident prior to transfer.

There was no evidence in the clinical file that a completed transfer form accompanied the resident in one instance. During emergency transfers, communications between the approved centre and the receiving facility were not documented and followed up with a written referral. Copies of all records relevant to the resident transfer were not retained in the resident’s clinical file.

The approved centre was non-compliant with this regulation because full and complete relevant information about the resident was not provided to the receiving hospital at the time of transfer, 18 (1).
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 June 2018, as was the medical emergencies policy. The policies and procedures included all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had not 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 at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with individual care plans. Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, not less than every six months.

The files of five residents who had been in the approved centre for over six months were examined. The six-monthly general health assessments consistently documented the following: physical examination, blood pressure, and medication review. However, none of the general health assessments examined included family or personal history, Body Mass Index, waist circumference, smoking status, nutritional status or dental health.

The files of four residents who were taking antipsychotic medication were reviewed. For residents on antipsychotic medication, an annual assessment took place for blood lipids. Two out of four files did not have a fasting glucose/HbA1c documented, three out of four did not contain a complete ECG, and none of the four records examined indicated that annual prolactin levels had been measured.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.
Residents had access to the following national screening programmes appropriate to age and gender: breast check, retina check (diabetics only), and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre. Residents had access to smoking-cessation programmes and supports.

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

a) Six monthly general health assessments were inadequately completed and did not reference the following: family/personal history, Body Mass Index, waist circumference, smoking status, nutritional status and dental health, 19 (1)(b).

b) The approved centre had not complied with the Mental Health Commission directive regarding health checks of residents on anti-psychotic medication for more than 12 months. Two out of four did not have a fasting glucose/HbA1c levels recorded, three out of four did not contain a complete ECG, and none of the four records examined indicated that annual prolactin levels had been measured, 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 April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The provision of information to residents was 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: The approved centre information booklet contained the following: housekeeping arrangements, including arrangements for personal property and mealtimes, visiting times and details of relevant advocacy and voluntary agencies. Residents were provided with the details of their multi-disciplinary team. Information was available on stands and noticeboards throughout the approved centre in relation to information on diagnosis.

Through interview with relevant staff and inspection of documentation, it was ascertained that the content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side effects. Residents had access to interpretation and translation services as required.

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed 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: The approved centre adhered to the policy in terms of staff dress and appearance. The general demeanour of staff was appropriate at all times. Staff discretion when discussing a resident’s condition or treatment needs was fitting to the approved centre. All residents were observed to be wearing clothes that respected their dignity.

There were no locks on the single bedrooms, as was appropriate to the resident profile. Bedroom doors were locked by staff unless there was a resident in the room. All external windows had mirrored foil applied, so they were not overlooked by any public areas. A public phone was available to residents in the Le Brun visitor room, ensuring privacy, while nursing staff facilitated private phone calls in Whitethorn. Noticeboards did not contain resident identifying information.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in December 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 not completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Appropriately sized communal rooms were provided in the approved centre. There was suitable and sufficient heating in the approved centre in both day areas and residents’ bedrooms, and windows were open to facilitate ongoing painting works in Whitethorn at the time of inspection. This meant that rooms were appropriately ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. Appropriate signage and sensory aids were provided to support resident orientation needs as appropriate. Works were ongoing in Whitethorn at the time of inspection in relation to the minimisation of ligature points to the lowest practicable level, based on a risk assessment.

Although there was a painting programme in Whitethorn at the time of inspection, the approved centre was not in a good state of repair internally. Scuffed paintwork was noted on walls and architraves. Skimmed plaster areas had not been painted. Repair work was unfinished or not commenced; there were broken call bells, skirting lino separating from the wall and older style sink units in poor repair. Two dormitories had extra beds stored in them, the floor covering throughout Whitethorn was old, mismatched, torn, and, in need of replacement. Le Brun was in need of repainting and minor decorative
repairs. There was a checklist for a flooring upgrade, painting, lighting, heating, sockets, call bells, and a sluice room upgrade. The approved centre was clean, hygienic, and free from offensive odours, notwithstanding the ongoing painting job.

There was a sufficient number of toilets and showers for residents in the approved centre. There was a dedicated laundry room with modern machines, which addressed the personal laundry needs of all residents in the approved centre. Bedrooms were appropriately sized to address ambulant residents’ needs but could have been more spacious for residents using mobility aids. Hoists and standing aids were available. Substantial changes to the approved centre were not deemed to be needed, and a rolling programme of works was in operation. Night staff moved to the bedroom area at night to ensure isolated areas of the approved centre were monitored.

The approved centre was non-compliant with this regulation because the premises had not been maintained in good structural and decorative condition, 22 (1).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in February 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: All entries in the MPAR were legible, and written in black, indelible ink. Medication was reviewed at least six-monthly or more frequently where there was a significant change in the resident’s care or condition. Prescriptions were not altered when changes were required, and where there was an alteration in the medication order, the pertinent medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical professionals. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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. Expiration dates of medications were verified prior to administration, and expired medications were not administered. Schedule 2 controlled drugs were checked by two staff members, against the delivery form and details entered on the controlled drug book. Directions to crush medication were only accepted from the residents’ medical practitioner. The pharmacist was consulted about the type of medication preparation to be used and the medical practitioner documented that medication was to be crushed accordingly.

Medication was stored in the appropriate environment as indicated on the label or packaging of the medication, or as advised by the pharmacist. A small amount of dust was observed in the medical room in Whitethorn due to the recent refurbishment and the building works. There was no cleaner in the Whitethorn part of the approved centre on inspection, meaning that medication storage areas were not incorporated in the cleaning and housekeeping schedules. Food and drink was not stored in areas used
for the storage of medication. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication administration cupboard remained locked at all times and was secured in a locked room.

An inventory of medications was not conducted on a monthly basis.

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 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 operational policy in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in December 2017. It also had an associated Safety Statement, dated March 2019. The policy and the safety statement included all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to 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: Health and Safety was only assessed against the approved centre’s written policies and procedures. Health and safety practices within the approved centre were not assessed.

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

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in April 2017. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: The implementation and effectiveness of the staff-training plan was 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 been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: At the time of inspection, there was no occupational therapist (OT) for either Whitethorn or Le Brun. Through interview, it was established that an appropriately qualified staff member was on duty and in charge at all times, and this was documented. There was no written staffing plan in the approved centre. 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 group profile.

All healthcare professionals were trained in the following: fire safety, basic life support, and management of violence and aggression/PMAV. Not all staff were trained in the Mental Health Act 2001 and Children First. Training was in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. This included manual handling, infection control and prevention, dementia care, risk management and treatment, incident reporting, and protection of children and vulnerable adults. However, not all of the aforementioned staff were trained in end of life care and resident rights.
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 made available to staff throughout the approved centre.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (25)</td>
<td>25 100%</td>
<td>25 100%</td>
<td>25 100%</td>
<td>25 100%</td>
<td>25 100%</td>
</tr>
<tr>
<td>Consultant Psychiatrist (2)</td>
<td>2 100%</td>
<td>2 100%</td>
<td>2 100%</td>
<td>2 100%</td>
<td>2 100%</td>
</tr>
<tr>
<td>Medical (2)</td>
<td>2 100%</td>
<td>1 50%</td>
<td>2 100%</td>
<td>1 50%</td>
<td>1 50%</td>
</tr>
<tr>
<td>Other (21)</td>
<td>21 100%</td>
<td>21 100%</td>
<td>21 100%</td>
<td>21 100%</td>
<td>21 100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Le Brun</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN or RGN</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNS (Activities)</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whitethorn</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN or RGN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNS (Activities)</td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</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) There was a lack of access to occupational therapy for the residents of both Whitethorn and Le Brun units, meant that the skill mix of staff was not appropriate to the assessed needs of residents, 26 (2).

b) Not all staff were trained in the Mental Health Act (2001), 26 (5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. The policy was last reviewed in December 2017. The policy addressed all of the requirements of the Judgement Support Framework, with the exception of the way in which entries in residents’ records are made, corrected, and overwritten.

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 not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All residents’ records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents’ status and the care and treatment being provided. Records were developed and maintained in a logical sequence, kept in good order, and had no loose pages. Resident records were maintained appropriately. They were written legibly in black indelible ink and were readable when photocopied. Entries were factual, consistent, accurate and did not contain jargon, unapproved abbreviations or meaningless phrases. Each entry included the date and was followed by an appropriate signature. However, entries did not consistently contain times using the 24-hour clock.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering, and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre. Records were maintained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

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

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

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

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

All operating policies and procedures requiring a review within three years for had an up to date policy in place. The approved centre was also consistent in terms of management of obsolete versions of operating policies and procedures; these were retained but removed from possible access by staff.

Where the approved centre utilised generic policies, there was a written statement to this effect, which was compliant in terms of being reviewed at least every three years. All generic policies in effect were appropriate to this approved centre and the resident group profile.

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 last reviewed in December 2017. The policy addressed all of the requirements of the Judgement Support Framework, including:

- The process for managing complaints,
- The process for the raising, handling, and investigation of complaints from any person.
- The methods available to all persons to make a complaint
- The confidentiality requirements in relation to the management of complaints.

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

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was analysed. Senior management had considered details of the analysis. Required actions had 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. Through the “Your Service, Your Say” policy was apparent that a consistent and standardised approach was implemented for all management of all complaints. Information in relation to the complaints procedure was available in the approved centre in the form of an information booklet. Full details of the complaints procedure were publicly displayed.

Residents, their family, representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were investigated promptly and handled appropriately and
The registered proprietor ensured that the quality of the service, care, and treatment of a resident were not adversely affected by reason of the complaint being made. Complaints that were deemed to be more severe than minor were dealt with by the nominated person and recorded accordingly in the complaints log. Since the last inspection, no complaints had been escalated to the complaints officer. Details of all complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in April 2017. The policy addressed requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- The person responsible for the completion of six-monthly incident summary reports.
- Capacity risks relating to the number of residents in 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. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.
Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported, and monitored. Clinical risks were documented on the risk register, as deemed appropriate.

Health and safety risks were assessed and monitored by the approved centre in accordance with the relevant legislation. Certain ligature points remained in the approved centre, but had been mitigated appropriately. Corporate risks were also identified and monitored by the approved centre. These were documented in the risk register, as evidenced on inspection through the relevant documentation. The approved centre had implemented plans to reduce risks to residents while works to the premises were taking place. There was no named risk manager in the approved centre; each staff member was deemed to manage the risks identified.

Individual risk assessments were completed prior to and during resident transfer. There was involvement of multi-disciplinary team members (MDT) in the development, implementation, and review of individual risk management processes, and the requirements for the protection of vulnerable adults within the approved centre. These requirements were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format, as shown through inspection of relevant documentation. All clinical incidents were reviewed by the MDT at their regular team meeting.

The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. Information was provided anonymously at resident level. The approved centre indicated that there was an emergency plan that specified responses by the approved centre staff to possible emergencies; the emergency plan incorporated evacuation procedures.

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

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

INSPECTION FINDINGS

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

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

| COMPLIANT |

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

#### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently at the entrance of the Le Brun unit in the approved centre.

The approved centre was compliant with this regulation.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
Part 4 of the Mental Health Act 2001: Consent to Treatment, was not applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
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.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. They were last reviewed in January 2018, October 2017, and March 2019 respectively. The policies included all of the policy-related criteria for this code of practice.

Training and Education: Not all relevant staff had signed to indicate that they had read and understood the admission policy. There was documentary evidence that relevant staff had read and understood the transfer and discharge policies.

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

Evidence of Implementation:

Admission: The file of one resident who had recently been admitted to the approved centre. This admission had been on the basis of a mental illness and an admission assessment had been completed. The approved centre had a key worker system in place. A full physical health examination had been completed for the resident on admission.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: Discharge was not inspected against as no resident had been discharged since the last inspection.

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

   a) The approved centre was non-compliant with Regulation 18: Transfer of Residents, 30.1.
   b) Not all staff had signed to say that they had read and understood the policy on admission, 9.1.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 19: General Health

<table>
<thead>
<tr>
<th>Reason ID : 10000243</th>
<th>Six monthly general health assessments were inadequately completed and did not reference the following: family/personal history, Body Mass Index, waist circumference, smoking status, nutritional status and dental health, 19(1)(b).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>A new Physical Health Assessment Form will be introduced to meet the documentation requirements in relation family/personal history, Body Mass Index, waist circumference, smoking status, nutritional status and dental health.</td>
<td>Review Clinical file / six-monthly general health assessment form</td>
<td>Achievable</td>
<td>31/10/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Resident General health examination checklists are introduced within the approved centre. All clinical files will be reviewed bi-monthly for the completion of general health needs reviews</td>
<td>Regular analysis</td>
<td>Achievable</td>
<td>31/10/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000244</th>
<th>The approved centre had not complied with the Mental Health Commission directive regarding health checks of residents on anti-psychotics for more than 12 months. Two</th>
</tr>
</thead>
</table>
out of four did not have a fasting glucose recorded, three out of four did not contain a complete ECG, and none of the four records examined indicated that annual prolactin levels had been measured, 19 (1)(b).

<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>A new Physical Health Assessment Form will be introduced to meet the documentation requirements in relation to general health checks of residents on antipsychotics for more than 12 months. This includes monitoring of residents’ ECG and annual blood prolactin levels.</td>
<td>Review Clinical file / six-monthly general health assessment form / ICP</td>
<td>Achievable</td>
<td>31/10/2019</td>
<td>Admitting clinician Registrar Consultant</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Six monthly general examination checklists introduced to comply with the Mental Health Commission directive regarding residents’ general health check. All clinical files will be reviewed bi-monthly for the completion of</td>
<td>Review Checklist / Clinical file / ICP</td>
<td>Achievable</td>
<td>31/10/2019</td>
<td>Admitting clinician Registrar Consultant</td>
</tr>
<tr>
<td>general health needs reviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Regulation 16: Therapeutic Services and Programmes  

<table>
<thead>
<tr>
<th>Reason ID : 10000245</th>
<th>The lack of occupational therapy input into the approved centre meant that residents did not have access to an appropriate range of therapeutic services, 16 (1).</th>
</tr>
</thead>
</table>
| **Corrective Action** | **Specific** Business case submitted and approved for additional OT staffing needs within the approved centre. Attempts to recruit staff previously and currently. Agency OT staffing (approved) for Psychiatry of Later Life OT services with joint governance from Mental Health and Primary Care OT Managers. Access to the onsite Seating Clinic facility via Primary Care Occupational Therapy. OT recruitment to commence immediately.  
**Measurable** Staffing analysis; Presence of OT with Dedicated in-patient commitment  
**Achievable/Realistic** Achievable  
**Time-bound** 31/12/2020  
**Post-Holder(s)** Head of service Occupational Therapy Managers Mental Health and Primary Care DSE Operational Management Team |
| **Preventative Action** | **Review current model of care to improve access to appropriate range of**  
**Measurable** Review / Analysis  
**Achievable** Achievable  
**Time-bound** 31/12/2020  
**Post-Holder(s)** Head of Service Occupational Therapy Managers Mental Health |
therapeutic services within the approved centre.

Executive Management Team CHEast
There was a lack of access to occupational therapy for the residents of both Whitethorn and Le Brun units, which meant that the skill mix of staff was not appropriate to the assessed needs of residents, 26 (2).

<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>There are on-going efforts to recruit sufficient number and skill mix of staff to meet residents’ identified needs. Business case submitted and approved for additional OT staffing needs within the approved centre. Agency OT staffing (approved) for Psychiatry of Later. Life OT services with joint governance from Mental Health and Primary Care OT Managers. OT recruitment to commence immediately</td>
<td>Presence of OT with Dedicated in-patient commitment</td>
<td>Achievable</td>
<td>31/12/2020</td>
<td>Head of Service Occupational Therapy Managers Mental Health and Primary Care DSE Operational Management Team</td>
</tr>
</tbody>
</table>

| Preventative Action | Workforce plan for Approved Centre to be developed to address skill mix, competencies,                                                                                                               | Workforce planning / Analysis                                             | Achievable           | 31/12/2020   | Head of Service Occupational Therapy Managers                       |
number and qualifications of staff. Analysis to identify opportunities to improve the processes for staffing within the approved centre.

<table>
<thead>
<tr>
<th>Reason ID : 10000248</th>
<th>Not all staff were trained in the Mental Health Act (2001), 26 (5).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Training needs analysis completed and schedule for training identified and circulated with all relevant MDTs. Staff have access to education and training resources, including local internet access, access to HSE Land, access to appropriate journal publications and HSE regional libraries.</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Review Staff training records and logs</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Achievable</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>31/08/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Heads of Discipline Relevant MDTs</td>
</tr>
</tbody>
</table>

| **Preventative Action** | Training and development plans are reviewed on an annual basis. |
| **Achievable** | Achievable |
| **Time-bound** | 31/12/2019 |
| **Post-Holder(s)** | Heads of Discipline |
| Review and analysis is completed within the mental health service to identify opportunities to improve staff training programme. |   |   |   |
## Regulation 18: Transfer of Residents

### Reason ID: 10000249

Full and complete relevant information about the resident was not provided to the receiving hospital at the time of transfer, 18 (1).

<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>A new Resident transfer Form is introduced within the approved centre to improve the communication and liaison between the service and the receiving facility. Copies of all records relevant to the service user transfer process are retained in the service user's clinical file.</td>
<td>Analysis is completed of each transfer to identify opportunities to improve information provision during transfers. A log of transfers is maintained and reviewed.</td>
<td>Achieved</td>
<td>01/08/2019</td>
<td>PIC MDT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Checklists are completed by the service to ensure comprehensive service user records have been transferred to the receiving facility.</td>
<td>Review transfer form/ Clinical File/ ICP</td>
<td>Achieved</td>
<td>01/08/2019</td>
<td>PIC</td>
</tr>
</tbody>
</table>
### Code of Practice on Admission, Transfer and Discharge to and from an approved centre

**Reason ID: 10000242**

<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>Policy dissemination session will be held within the approved centre in August and Sep 2019. Implemented PPPG signature log register for staff who have read and understood the policy.</td>
<td>Review of the PPPG signature log</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>HODs MDT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy dissemination planner in place for 2019</td>
<td>Analysis of Policy dissemination process</td>
<td>Achievable</td>
<td>30/09/2019</td>
<td>CNM3</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

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

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

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

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