Wood View

ID Number: AC0098

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Wood View
Merlin Park
Galway

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Mental Health Rehabilitation

Most Recent Registration Date:
15 March 2019

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

Inspection Team:
Dr Enda Dooley, MCRN004155, Lead Inspector
Martin McMenamin
Karen McCrohan

Inspection Date:
30 April – 3 May 2019

Previous Inspection Date:
16 – 19 October 2018

Inspection Type:
Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 28 November 2019

2019 COMPLIANCE RATINGS

REGULATIONS

24

RULES AND PART 4 OF THE MENTAL HEALTH

1

CODES OF PRACTICE

2

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

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

Dr Susan Finnerty

In brief

Wood View was a 16-bed continuing care mental health facility located in the Merlin Park University Hospital campus in Galway. It was registered for a maximum of 16 residents at its most recent registration renewal in March 2019. Most of the residents were elderly, many of who had been resident in the facility for many years. The approved centre was managed by the Rehabilitation and Recovery team. The facility currently consisted of 14 single bedrooms and one shared bedroom.

Overall, there has been an improvement in compliance with regulations, rules and codes of practice from 73% in 2017 and 71% in 2018, to 78% in 2019. Six compliances with regulations were rated excellent.

Conditions to registration

There were two conditions 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 registered proprietor 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 not in breach of Condition 1 and the approved centre was compliant with Regulation 22: Premises at the time of inspection.

Condition 2: To ensure adherence to Regulation 26: Staffing, the approved centre shall ensure that residents of the approved centre have access a suitably qualified psychologist, in accordance with their assessed needs as documented in their individual care plan, by no later than 30 June 2019.

Finding on this inspection: This inspection was carried out prior to 30 June 2019.
Safety in the approved centre

- Hazards and ligature points had been minimised throughout the approved centre.
- The storage of medication was carried out in a safe manner.

However:

- Although there was an improvement in the level of mandatory training, not all health care staff had received up-to-date training in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001 and Children First.
- There were no proper facilities for the refrigeration of food and fridge temperature logs were not maintained. At the time of the inspection, fridge temperatures were recorded above five degrees Celsius on several occasions, despite a recent EHO report specifying that the safe critical limit for refrigeration of perishable foods was 0-5 degrees Celsius.
- There were a number of poor practices in the prescription and administration of medication:
  - One medication prescription and administration record (MPAR) did not record the stop date for each medication.
  - In three MPARs, the medical practitioner abbreviated micrograms and did not write it in full.
  - In three MPARs, a record of all medications administered to the resident was not detailed.
  - The medication dose to be given to the resident was not recorded clearly in one prescription.
  - Three MPARs contained illegible entries.

Appropriate care and treatment of residents

- Each resident had an individual care plan, which was multi-disciplinary and into which they had an input. Therapeutic activities were facilitated by the occupational therapist, music staff, nursing staff, and multi-task attendant. A number of dedicated spaces were provided for individual and group therapies. Groups were facilitated in the sitting room, dining room and in the dedicated activities room.
- Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Residents had access to speech and language therapy, dietetics, physiotherapy, chiropody, and podiatry.
- Residents on antipsychotic medication received an annual assessment of heart health through an electro-cardiogram assessment. Their glucose regulation and blood lipids were checked annually.

However:

- The multi-disciplinary team of the approved centre did not include a psychologist on this inspection and on the previous two years inspections. The residents’ unmet clinical psychological assessment needs were documented in their individual care plans.
- While residents had received a six-monthly general health assessment including a physical examination, the assessments had not been adequately completed in four cases reviewed:
  - Residents’ Body Mass Index was not recorded in four cases.
Residents’ family or personal history was not recorded in two cases.

None of the four residents received an assessment of their waist circumference. Weight was checked in all four cases.

Smoking status was not documented in three clinical files.

Nutritional status such as diet and physical lifestyle, including sedentary lifestyle was not documented in three clinical files.

Dental health assessments were not documented in any of the four clinical files.

Respect for residents’ privacy, dignity and autonomy

- The approved centre was adequately lit, heated, and ventilated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise.
- The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment.
- There was a cleaning schedule implemented within the approved centre. The approved centre was clean, hygienic, and free from offensive odours.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. A number of locks in single bedrooms were broken at the time of the inspection.
- Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.
- Only one bedroom was shared between two residents and the bed screening was adequate; it ensured that their privacy was not compromised. Residents were facilitated to make private phone calls. A number of residents had their own mobile phones and other residents had access to a mobile phone in the approved centre.

Responsiveness to residents’ needs

- The approved centre provided access to recreational activities on weekdays and during the weekend. Accessible, suitable and graphically engaging information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities was widely displayed on noticeboards. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity.
- The residents were free to receive visitors when they wished and there was a visiting area.
- Information was available in written form about the approved centre, the residents’ diagnoses and medication.
- There was a satisfactory complaints procedure in place.

Governance of the approved centre
• The approved centre was part of Community Healthcare West, previously Community Healthcare Organisation (CHO) 2. Governance was through the Overarching Clinical Governance Mental Health Team meetings, Quality and Safety Committee meetings, and the Rehabilitation and Recovery Service Business meetings. Minutes of these meetings indicated an active governance process relating to issues such as clinical risk, policy development, audit, staffing, overall risk management, and training.

• The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.

• Across disciplines, staffing deficiencies, either absolute as in the case of dedicated psychology input to the approved centre or relative where the staffing allocation was not sufficient to meet all resident needs, were a stated source of risk. The geographical remit of the responsible clinical team posed difficulties when allied with relative multi-disciplinary staffing deficiencies.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A new activities room was in use to facilitate an expanded range of therapeutic inputs.

2. Augmented therapeutic staffing with the introduction of a new Activities Nurse and increase Occupational Therapy inputs.

3. Art Therapy sessions were introduced.

4. Communication board was introduced to facilitate communication with hearing impaired resident.

5. Improved Wi-Fi access to facilitate use of ‘Alexa’ by sight impaired resident.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Wood View was a mental health facility located in the Merlin Park University Hospital campus. It was registered for a maximum of 16 residents at its most recent registration renewal in March 2019. Previously it had been registered for 21 beds but in the interests of facilitating single room occupancy this number had been decreased. The typical profile of residents was of a gradually aging cohort, many of who had been resident in the facility for many years. Notwithstanding this continuing care picture, the residence was managed by the Rehabilitation and Recovery team.

The facility currently consisted of 14 single bedrooms and one shared bedroom. The service had a stated aim to have all single bedroom accommodation. Resident bedrooms and communal accommodation were located on the ground floor of the unit. A former bedroom had been converted to an activities room, which was used to provide therapeutic activities as well as facilitating visits when not otherwise required. The unit had an attached garden, which was freely accessible to residents.

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>16</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>16</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>1</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>2</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>15</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 Healthcare West, previously Community Healthcare Organisation (CHO) 2. A number of regular operational meetings dealing with governance issues relevant to the approved centre took place. These included the Overarching Clinical Governance Mental Health Team meetings, Quality and Safety Committee meetings, and the Rehabilitation and Recovery Service Business meetings. Minutes of these meetings were provided to the inspection team. These indicated an active governance process relating to issues such as clinical risk, policy development, audit, staffing, overall risk management, and training.

Heads of clinical disciplines had submitted governance questionnaires requested by the inspection team and these greatly assisted in providing an overall perspective on governance within the approved centre. Across the disciplines, staffing deficiencies, either absolute as in the case of dedicated psychology input to the approved centre or relative where the staffing allocation was not sufficient to meet all resident needs, were
a stated source of risk. The geographical remit of the responsible clinical team posed difficulties when allied with relative multidisciplinary staffing deficiencies.

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 6: Food Safety</td>
<td>✓</td>
<td>X</td>
<td>Low</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>Low</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td>X</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 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</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.
### 4.3 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>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>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.

Two residents met with the inspectors. They commented positively on their experience in the approved centre and no issues were raised which required the immediate intervention of management. No resident chose to return a leaflet questionnaire outlining their experience.
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:

- Clinical Director
- Area Director of Nursing
- Registered Proprietor
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Occupational Therapy Manager
- Director of Psychology
- Senior Occupational Therapist
- Maintenance Foreperson

Apologies were received from the Executive Clinical Director, the Area Lead for Mental Health Engagement, and from the Principal Social Worker.

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 service clarified that the identified issues relating to fridge temperatures were being resolved. Regarding the maintenance of property logs, the service was advised to devise a protocol to ensure that an update of logs was undertaken at suitable intervals.
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 November 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
(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, which was last reviewed in June 2017. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policies. 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:** The approved centre’s menus were not approved monthly by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs, this was due to a lack of funding. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Hot meals were offered daily. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly. Each resident was provided with bottled water due to the legionella risk in Merlin Park Hospital.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. The approved centre did not use an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in November 2016. The policy included the requirements of the Judgement Support Framework with the following exceptions:
   - Food preparation, handling, storage, distribution and disposal controls.
   - The management of catering and food safety equipment.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date training in food safety and hygiene commensurate with their role. Staff training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. While a food temperature log sheet was maintained food temperatures were not consistently recorded in line with food safety recommendations. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

All food was prepared in and delivered from the main kitchen in Merlin Park, with the exception of breakfast which was prepared in the approved centre. There were no proper facilities for the refrigeration of food. Fridge temperature logs were not maintained. At the time of the inspection, fridge temperatures were recorded above five degrees Celsius on several occasions, despite a recent EHO report specifying that the safe critical limit for refrigeration of perishable foods is 0-5 degrees Celsius.

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

   a) Proper facilities were not provided for the refrigeration of food, 6(1)(b).
   b) Food temperature was not consistently recorded in line with food safety recommendations, 6(1)(c).
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: All residents were admitted to the approved centre on a long-term basis and had adequate supplies of personal clothing. While it was possible to provide residents with replacement clothing if the need arose, it was not considered necessary to keep a supply of generic emergency clothing in this approved centre.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents' clothing was stored in wardrobes in their bedrooms. Residents had an adequate supply of individualised clothing, and they changed out of nightclothes during daytime hours unless specified otherwise in individual care plans.

The approved centre was compliant with this regulation. The quality assessment was deemed satisfactory as monitoring and implementation of emergency clothing was not deemed necessary in the approved centre.
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 policy in relation to residents’ personal property and possessions, which was last reviewed in October 2016. 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 were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

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

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP). The checklist was not updated on an ongoing basis in accordance with the approved centre’s policy.

Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions. There was a secure safe in the nurses’ office. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
Regulation 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 October 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 record 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 on weekdays and during the weekend. Accessible, suitable and graphically engaging information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities was widely displayed on noticeboards. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Activities included walks and minor gardening projects. Activities were developed, maintained, and implemented with resident involvement. Resident feedback and resident preferences were taken into account. Records of resident attendance at events were maintained in group records or in the clinical files.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 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 November 2016. 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, and Mass took place monthly in the approved centre. Chaplains visited weekly and it was possible for residents to attend Mass in the Church within Merlin Park Hospital campus. Residents had access to multi-faith chaplains, if required. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in June 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: There were no current restrictions on residents’ rights to receive visitors which meant a documented analysis to identify improvement was not justified.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed at the hospital entrance and in each ward of the approved centre. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. The new activities room doubled as a designated visitors’ room in the evenings. During the day visitors could be facilitated within the two sitting rooms, the dining room or the garden area. The majority of the visitors took the residents out so no issue arose.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting areas available were suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. 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, fax, and telephone if they wished. Residents did have access to the internet but staff indicate that no resident had requested access. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in October 2018. The policy addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

There were no searches conducted in the approved centre since the last inspection. Therefore, the approved centre was assessed under the two pillars of processes and training and education only.

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 policies and protocols in relation to care of the dying. The care of the dying policy was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in November 2016. The policy included the requirements of the Judgement Support Framework with the exception of the timeframes for assessment planning, implementation, and evaluation of the ICP.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. 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: All residents in the approved centre lived there on a long-term basis. Each resident had an ICP, ten of which were inspected. A key worker was identified to ensure continuity in the implementation of a resident’s ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All inspected ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, and next of kin, as appropriate. The ICPs identified the resident’s assessed needs, defined appropriate goals, and specified the care and treatment required to meet the identified goals including the frequency and staff responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan.

The ICP was reviewed by the MDT in consultation with the resident every three months. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews. When a resident declined or refused a copy of their ICP, this was not recorded, including the reason, if given.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
Regulation 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 therapeutic services and programmes, which was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log to indicate that they had read and understood the policy on therapeutic services and programmes. All clinical staff interviewed were able to articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: There was evidence of ongoing monitoring of the range of therapeutic services and programmes provided to ensure that they met the assessed needs of residents. A documented analysis was completed to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: A list of therapeutic services and programmes provided within the approved centre was available to residents. The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines.

The therapeutic services and programmes provided by the approved centre were not appropriate and did not meet the assessed needs of the residents. The multi-disciplinary team of the approved centre did not include a psychologist on this inspection (2019), and on the previous two years inspections (2017, 2018). The residents’ unmet clinical psychological assessment needs were clearly documented within the residents’ individual care plans.

Where a resident required a therapeutic service or programme that was not provided internally, which was mainly psychology services, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location. Galway training centre services and Ceim Eile Day Centre services were, however, offered to residents.

Adequate resources and facilities were available. Therapeutic activities were facilitated by the occupational therapist, music staff, nursing staff, and multi-task attendant. The unit had its own minibus, which was 12 years old. A quantity of money was available from petty cash. A number of dedicated spaces were provided for individual and group therapies. Groups were currently facilitated in the sitting room, and dining room and in the dedicated activities room. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

The approved centre was non-compliant with this regulation for because the registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and program.
programmes in accordance with his or her care plan. Residents had no access to psychological 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, which was last reviewed in June 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre in an emergency was examined. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Information accompanied the resident upon transfer to a named individual. The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident’s needs.

Relevant documentation was issued as part of the transfer, with copies retained, including a nursing referral letter and a copy of the resident’s Medication, Prescription, and Administration Record. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident’s clinical file.

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

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Staff in the approved centre had an emergency resuscitation trolley, which was checked daily. They had access at all times to an Automated External Defibrillator. The approved centre did not have an emergency trolley, they phoned 999 emergency services instead. The four clinical files inspected showed that residents received appropriate general health care interventions in accordance with their documented identified needs in their ICPs. A fifth clinical file indicated that the resident refused a physical examination and associated tests. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs.

Residents’ general health needs were monitored and assessed at least every six months. While the four residents had received a six-monthly general health assessment including a physical examination, the assessments had not been adequately completed. Residents’ Body Mass Index was not checked and recorded in four cases. Residents’ family or personal history was not recorded in two cases. None of the four residents received an assessment of their waist circumference. Weight was checked in all four cases. Smoking status was not documented in three clinical files. Nutritional status such as diet and physical lifestyle, including sedentary lifestyle was not documented in three clinical files. Dental health assessments were not documented in any of the four clinical files.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Residents had access to speech and language therapy, dietetics, physiotherapy, chiropody, and podiatry. Residents on antipsychotic medication received an annual
assessment heart health through an electro-cardiogram assessment. Their glucose regulation and blood lipids were checked annually, but prolactin levels were not assessed and documented in four clinical files.

Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre. Records were available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing.

The approved centre was non-compliant with this regulation because the six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively assess each resident’s general health needs. The assessment did not include family history, Body Mass Index, waist circumference, smoking and nutritional status, dental review, or prolactin levels in all cases, 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 operational policy and procedures in relation to the provision of information to residents, which was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to 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, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with an information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents’ rights. The printed booklet was not available in the required formats to support resident needs, there was no braille or large print version of the information handbook available. Staff verbally communicated information to residents with visual impairments. In relation to residents who were deaf, staff provided a visual means of necessary information. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents’ needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side effects. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training, monitoring, and evidence of implementation pillars.
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 relation to resident privacy, which was last reviewed in October 2017. The policy addressed all of the requirements of the Judgement Support Framework.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed 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 policies were being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members interacted with residents in a respectful manner. Staff were discreet when discussing residents’ condition or treatment needs. Residents wore clothing that respected their privacy and dignity.

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

Only one bedroom was shared between two residents and the bed screening was adequate, it ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls. A number of resident had their own mobile phones and other residents had access to a mobile phone in the approved centre.

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

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in March 2019. The policy addressed all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. There was a sufficient number of toilets and showers for residents in the approved centre. All resident bedrooms were appropriately sized to address residents’ needs. There was sufficient space for residents to move about, including outdoor spaces. Given the incapacities of some residents, appropriate signage and sensory aids were not provided in all cases to support resident orientation needs.

Hazards and ligature points had been minimised. The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. There was a cleaning schedule implemented within the approved centre. The approved centre was clean, hygienic, and free from offensive odours.

COMPLIANT
Quality Rating Satisfactory
Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. A new centralised electronic maintenance requisition system had been introduced. Relevant request and approvals were allocated on recent and current new maintenance agreements between Merlin Park Hospital and PCCC.

Current national infection control guidelines were followed. Back-up power was available to the approved centre. Heat and power was supplied from Merlin Park Hospital. The approved centre had a designated sluice room, a designated cleaning room, and a designated laundry room. The approved centre provided assisted devices and equipment to address resident needs. Remote or isolated areas of the approved centre were monitored.

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 and evidence of Implementation pillars.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication. It was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were not recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

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

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

One MPAR did not record the stop date for each medication. Three MPARs abbreviated micrograms and did not write it in full. In three MPARs, a record of all medications administered to the resident was not detailed. The medication dose to be given to the resident was not recorded clearly in one prescription. Three MPARs contained illegible entries.

The medication trolley and medication administration cupboard remained locked at all times and secured in a locked room. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Refrigerators used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. An inventory of
medications was conducted on a monthly basis checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.

Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was non-compliant with this regulation because they did not have suitable practices relating to the prescription and administration of medications:

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

b) In three MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident, 23(1).

c) The dose to be given was not recorded clearly in one prescription, 23(1).

d) Three MPARs contained illegible entries, 23(1).
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in November 2018. The policy addressed all the requirements of the Judgement Support Framework.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements, which was last reviewed in March 2018. The policy and procedures addressed the requirements of the Judgement Support Framework, with the exception of staff performance and evaluation 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. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place which specified the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment.

Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. This rota indicated that an appropriately qualified staff member was on duty and in charge at all times.

The skill mix of staffing was inadequate to meet residents’ needs. Residents had no access to clinical psychology services, as documented under Regulation 16: Therapeutic Services and Programmes. A written staffing plan was not available within the approved centre. Staff were trained in line with the assessed needs of the resident group profile and of individual residents. Staff were trained in areas such as dementia care, risk management and treatment, incident reporting, manual handling, infection control and prevention (including sharps, hand-hygiene techniques, and use of personal protective equipment),
end of life care, recovery-centred approaches to mental health care and treatment, resident rights, caring for residents with an intellectual disability, and the protection of children and vulnerable adults.

Not all health care staff had received up to date training in the following:

- Fire safety
- Basic Life Support
- Management of violence and aggression
- The Mental Health Act 2001.
- Children First

All staff training was documented and staff training logs were maintained by individual staff members.

<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 (16)</td>
<td>12</td>
<td>75%</td>
<td>13%</td>
<td>12</td>
<td>74%</td>
</tr>
<tr>
<td>Medical (2)</td>
<td>1</td>
<td>50%</td>
<td>1</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>Occupational Therapist (4)</td>
<td>4</td>
<td>100%</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Psychologist (0)</td>
<td>-</td>
<td>%</td>
<td>-</td>
<td>-</td>
<td>%</td>
</tr>
</tbody>
</table>

The following is a table of 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></td>
<td>CNM2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Wood View</td>
<td>MTA</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.25 WTE</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.15 WTE</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Multi-task Assistant (MTA)

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the management of violence and aggression, and Children First, 26(4).

b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
c) The registered proprietor did not ensure that the skill mix of staff was appropriate to the assessed needs of residents; residents had no access to clinical psychology services 26(2).
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 three written policies and procedures in relation to the maintenance of records, which were last reviewed in March 2017. The policy addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence Of Implementation: 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. Resident records were physically stored together, where possible. Not all resident records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation.

Only authorised staff made entries in residents’ records, or specific sections therein. Records were legible and written in black indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training, 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 up-to-date, electronic register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in June 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 time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: This was not applicable to this approved centre at the time of the inspection. As there was only one involuntary patient in the approved centre at the time of the inspection, it was not feasible to undertake audit or analysis to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

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

The approved centre was compliant with this regulation.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence Of Implementation: There was a nominated person responsible for dealing with all complaints available and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the service user’s information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made through noticeboards and information booklets. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

There were no formal complaints lodged since the last inspection. Minor complaints were documented separately. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. Minor complaints were documented in the resident community meetings. A complaints log was maintained.

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All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in March 2018. The policy addressed the requirements of the Judgement Support Framework with the following exceptions:

- The process for communication.
- The escalation of emergencies to management.

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. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence Of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.
Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and seclusion, and at resident admission and transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained but were effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format, and were recorded on the DATIX system. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The risk manager reviewed incidents for any trends or patterns occurring in the service.

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

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate and attached registration conditions were displayed prominently 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.
9.0 Inspection Findings – Mental Health Act 2001

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The inspection team examined the clinical file of one detained patient who was identified as being in continuous receipt of medication for a period in excess of three months. The patient’s ability to agree to receive continued treatment was assessed by the consultant psychiatrist. The result of the assessment was that the patient lacked capacity to consent. This was documented.

A Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been appropriately completed. It included details of the discussion with the patient on the nature and purpose and the effects of the medication. Any views expressed by the patient were recorded. Authorisation was provided by a second consultant psychiatrist.

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** There was a written policy in relation to the use of physical restraint. The policy was last reviewed in April 2018. The policy included details of the following:

- The provision of information to residents regarding physical restraint.
- The individuals authorised to initiate and conduct physical restraint.
- The staff training requirements relating to physical restraint.

**Training and Education:** Not all staff involved in physical restraint had signed the policy log to indicate that they had read and understood the policy.

**Monitoring:** An annual report on the use of physical restraint had been completed.

**Evidence of Implementation:** Two episodes of physical restraint were inspected. Physical restraint was only used in exceptional circumstances and as a last resort, when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident’s unsafe behaviour. In all cases, the restraint order lasted for 30 minutes maximum.

Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint. Residents’ next of kin were informed about the physical restraint. The residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of PR.

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

**The approved centre was non-compliant with this code of practice because not all staff involved in physical restraint had signed the policy log to indicate that they had read and understood the policy, 9.2(b).**
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to admission, transfer, and discharge. The admission policy was last reviewed in November 2016, the transfer policy was last reviewed in June 2017, and the discharge policy was last reviewed in March 2018. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident received a full physical examination. The resident’s family member/carer/advocate were involved in the admission process, with the resident’s consent. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, current and historic medication, a risk assessment, work situation, education, and dietary requirements. The admission assessment undertaken did not assess the resident’s medical history and current mental state. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged to a nursing home was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident’s family. A pre-discharge assessment was completed, which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to the general practitioner within three days. A comprehensive discharge summary was issued within 14 days, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, and risk issues such as signs of relapse.

The approved centre was non-compliant with this code of practice because of the following reasons:
a) Audits had not been completed on the implementation of and adherence to the admission, and discharge policies, 4.19.

b) The admission assessment undertaken did not assess the resident’s medical history and current mental state, 15.3.
# Appendix 1: Corrective and Preventative Action Plan

## Regulation 6 Food Safety

<table>
<thead>
<tr>
<th>Reason ID: 10000330</th>
<th>Corrective Action: Proper facilities were not provided for the refrigeration of food, 6 (1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>Thermostat on the fridge repaired</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Daily readings (x3) recorded on activity sheet and signed off by staff member on duty</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Daily activity sheets audited by Joe Barrett (Food and Safety Officer)</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>03/09/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Joe Barrett (Food and Safety Officer)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Thermostat on fridge repaired</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>New Thermometer obtained to record random readings x3 daily</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Monitored daily</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>No barriers to implementation</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
<td>03/09/2019</td>
</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Domestic staff on duty daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000331</th>
<th>Corrective Action: Food temperature was not consistently recorded in line with food safety recommendations, 6(1)(c).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>Thermometer obtained to record random temperatures x3 daily inside the fridge Fridge thermostat repaired</td>
</tr>
<tr>
<td><strong>Measurable</strong></td>
<td>Daily recordings taken x3 and recorded in Activity sheet in Kitchen-signed by staff member on duty</td>
</tr>
<tr>
<td><strong>Achievable/Realistic</strong></td>
<td>Activity sheets</td>
</tr>
<tr>
<td><strong>Time-bound</strong></td>
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<td><strong>Achievable/Realistic</strong></td>
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</tr>
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<td><strong>Time-bound</strong></td>
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</tr>
<tr>
<td><strong>Post-Holder(s)</strong></td>
<td>Domestic staff on duty daily</td>
</tr>
</tbody>
</table>

| Preventative Action | Thermostat on fridge repaired Thermostat obtained to record daily x3 readings inside the fridge | Recorded daily and Audited by Joe Barrett | No barriers to implementation | 03/09/2019 | Domestic staff on duty daily Joe Barrett (Food and Safety Officer) |
**Regulation 19 General Health**

**Reason ID : 10000329**

The six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively assess each resident’s general health needs. The assessment did not include family history, Body Mass Index, waist circumference, smoking and nutritional status, dental review, or prolactin levels in all cases, 19(1)(b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All residents are offered a comprehensive physical health review every six months with GP or NCHD attached to Rehabilitation &amp; Recovery Service Team - a comprehensive checklist of all necessary parameters is used to ensure all aspects of physical health are included</td>
<td>Physical health monitoring document reviewed at tiem of Recovery Plan review</td>
<td>Barrier is resident (patient) consent - a number of residents persistently decline to cooperate with physical health monitoring or aspects of monitoring</td>
<td>17/10/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Physical Health monitoring due dates are included in Residence Diary</td>
<td>Monitored at Recovery Plan review meetings as a standard</td>
<td>Document individual resident (patient) - non-cooperation Include in individual risk assessment</td>
<td>17/10/2019</td>
</tr>
</tbody>
</table>
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

| Reason ID : 10000333 | One MPAR did not record the stop date for each medication, 23(1). In three MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident, 23(1). The dose to be given was not recorded clearly in one prescription, 23(1). Three MPARs contained illegible entries, 23(1). |

<table>
<thead>
<tr>
<th><strong>Corrective Action</strong></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>1. Medication Kardex (MPAR) for all 15 residents are reviewed by NCHD every Friday afternoon to review all medications, indications and stop dates. 2. Visiting GP has agreed that he will not prescribe in the MPAR rather leave instruction about physical health medication for the NCHD or Consultant Psychiatrist to enter into MPAR</td>
<td>Weekly MPAR review Audit as per JSF</td>
<td>Immediately implemented after inspection visit</td>
<td>24/09/2019</td>
<td>Consultant Psychiatrist 0 Dr. Spelman Non-Consultant Hospital Doctor working with Rehabilitation &amp; Recovery Service team under the supervision of Dr. Spelman</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Preventative Action</strong></th>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPAR instruction Weekly review on Friday afternoon</td>
<td>Audit - Reaudit scheduled week commencing 14th October 2019</td>
<td>Feasible</td>
<td>19/10/2019</td>
<td>Consultant Psychiatrist NCHD</td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID: 10000338</th>
<th>Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the management of violence and aggression, and Children First, 26(4). Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Corrective Action</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Preventative Action</strong></td>
</tr>
</tbody>
</table>
### Code of Practice on the Use of Physical Restraint in Approved Centres

<table>
<thead>
<tr>
<th>Reason ID : 10000328</th>
<th>Not all staff involved in physical restraint had signed the policy log to indicate that they had read and understood the policy, 9.2 (b).</th>
</tr>
</thead>
</table>
| **Corrective Action**| **Specific**  
New Signature Bank put in place for all staff to sign off when they read and understood the policy  
**Measurable**  
CNM2 monitoring on a daily basis to ensure all staff sign when on duty  
**Achievable/Realistic**  
No barriers  
**Time-bound**  
22/09/2019  
**Post-Holder(s)**  
Pat Kiernan CNM2 Woodview |
| **Preventative Action**| **Specific**  
New Signature bank in place for all staff to sign when they have read and understood the policy  
**Measurable**  
CNM2 to monitor on an ongoing basis  
**Achievable/Realistic**  
No barriers to implementation  
**Time-bound**  
22/09/2019  
**Post-Holder(s)**  
Pat Kiernan CNM2 |
### Code of Practice on Admission, Transfer and Discharge to and from an approved centre

<table>
<thead>
<tr>
<th>Reason ID: 10000326</th>
<th>Audits had not been completed on the implementation of and adherence to the admission, and discharge policies, 4.19.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Audit subgroup established in Approved Centre</td>
</tr>
<tr>
<td></td>
<td>CNM2 will follow up on any recommendations from Audit</td>
</tr>
<tr>
<td></td>
<td>No Barriers</td>
</tr>
<tr>
<td></td>
<td>27/10/2019</td>
</tr>
<tr>
<td></td>
<td>Myriam McCann CNM2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Preventative Action</strong></th>
<th>Audiot Subgroup in Approved Centre established</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit and re Audit</td>
</tr>
<tr>
<td></td>
<td>No Barriers- Reaudit 22nd October 2019</td>
</tr>
<tr>
<td></td>
<td>27/10/2019</td>
</tr>
<tr>
<td></td>
<td>CNM2 Myriam McCann</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000327</th>
<th>The admission assessment undertaken did not assess the resident's medical history and current mental state, 15.3.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Standardised medical history and mental state examination included in Core Assessment on admission</td>
</tr>
<tr>
<td></td>
<td>Audit</td>
</tr>
<tr>
<td></td>
<td>No barrier to implementation</td>
</tr>
<tr>
<td></td>
<td>24/09/2019</td>
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<tr>
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<td>Consultant Psychiatrist - Dr. Spelman NCHD working with Rehabilitation &amp; Recovery Service under supervision of Dr. Spelman</td>
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<table>
<thead>
<tr>
<th><strong>Preventative Action</strong></th>
<th>Standardised Documentation for all admissions to residential approved centre.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit</td>
</tr>
<tr>
<td></td>
<td>No barrier to implementation</td>
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<td>Consultant Psychiatrist - Dr. Spelman NCHD working with Rehabilitation &amp; Recovery Service</td>
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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.