MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Cappahard Lodge

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

CAPPAHARD LODGE

Cappahard Lodge, Tulla Road, Ennis

Date of Publication:
Thursday 10 December 2020

ID Number: AC0167

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Psychology of Later Life (POLL)
Mental Health Rehabilitation

Most Recent Registration Date:
01 October 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

Inspection Team:
Rajeev Ramasawmy, Lead Inspector
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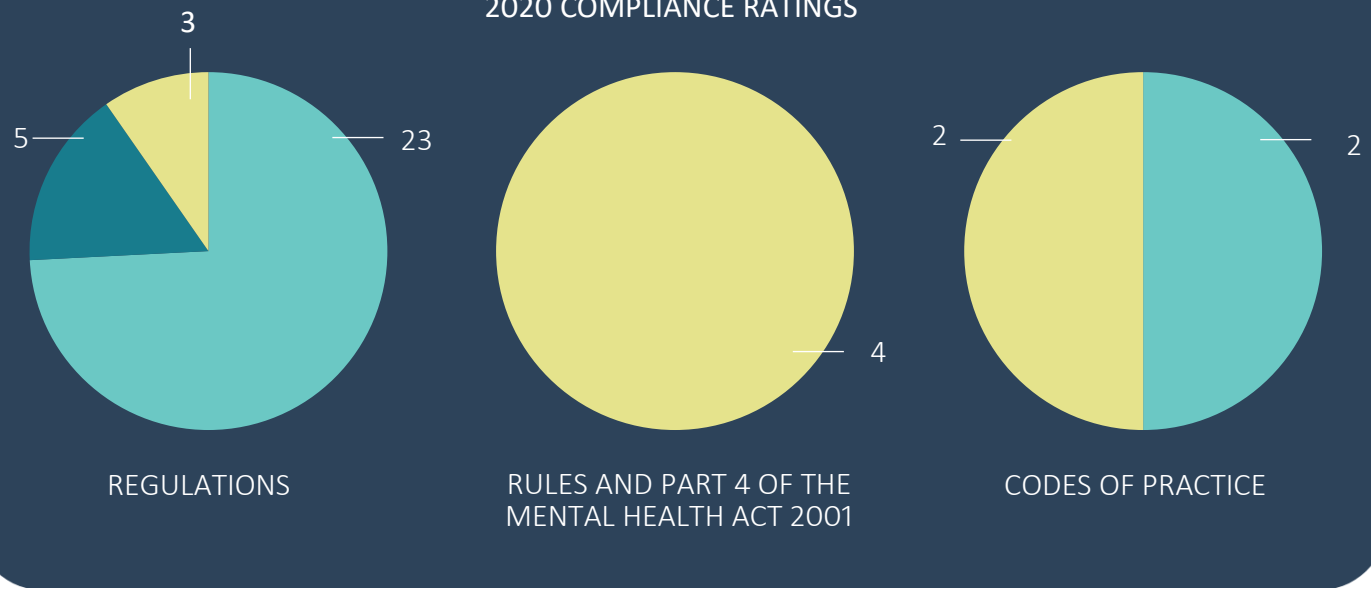
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
18 – 21 February 2020

Previous Inspection Date:
13 – 16 August 2019

Inspection Type:
Unannounced Annual Inspection

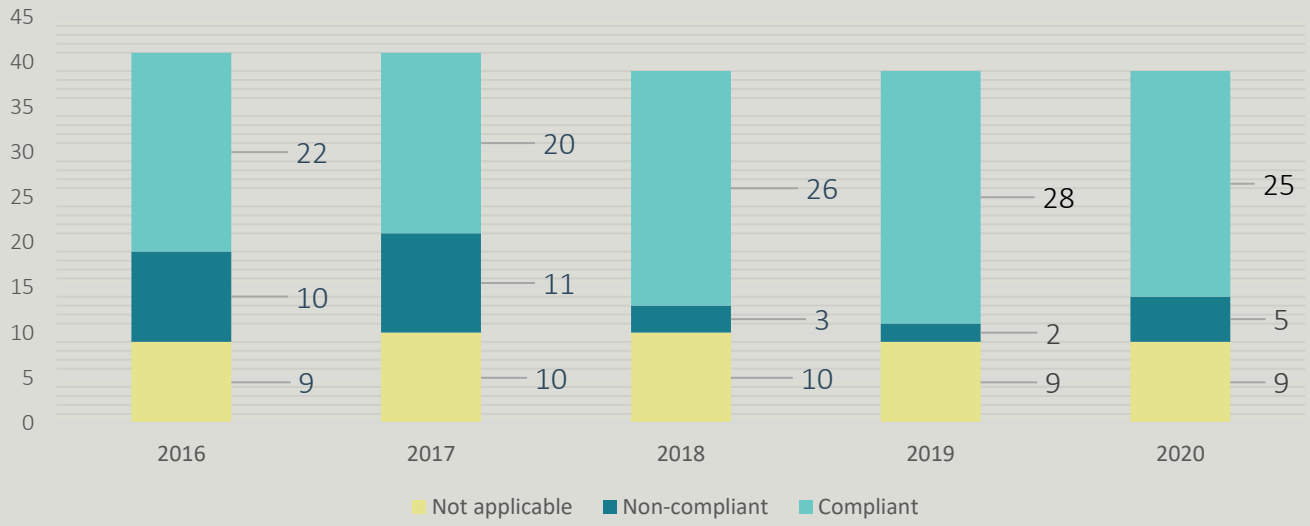
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

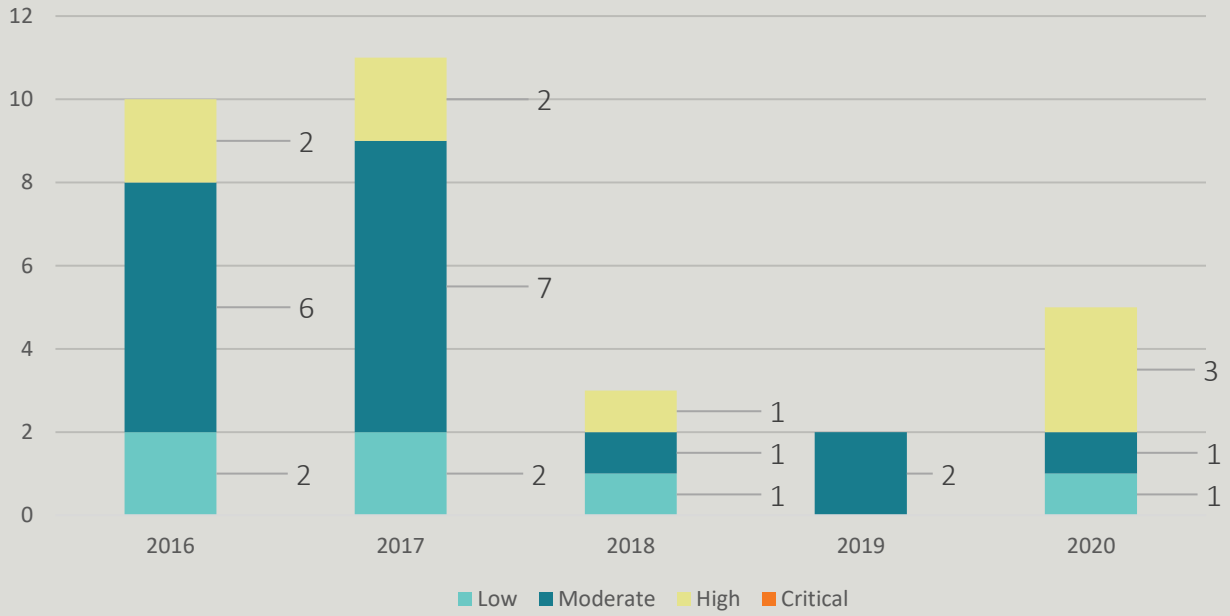
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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 2016 – 2020



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Cappahard Lodge was located in a suburban area on the outskirts of Ennis, Co. Clare. It was formerly a nursing home and had single bedroom accommodation for all the residents. Most of the residents had resided in the approved centre for over 6 months, some for many years. The approved centre was registered for 32 beds but had 15 residents at the time of admission.

There were two mental health teams: psychiatry of old age and a rehabilitation and recovery team. The majority of residents were under the care of the rehabilitation team.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	69%	65%	90%	93%	83%
Regulations Rated Excellent	1	1	8	15	13

Conditions to registration

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

Condition 1: *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

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

Safety in the approved centre

- Food safety was audited regularly. Kitchen areas were clean and had appropriate food and equipment storage facilities.
- Medication was ordered, prescribed and stored in a safe manner.
- Environmental hazards were minimised.

- There was an emergency plan in place that included an evacuation plan.

However:

- Ligature anchor points were evident in the approved centre.
- Not all healthcare professionals who worked in or attend the approved centre were trained in: fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act (2001).
- The administration of medication was not always documented in the correct manner.

Appropriate care and treatment of residents

- Each resident had an individual care plan.
- A GP visited the approved centre regularly. A six-monthly health assessment had been completed for each resident which included BMI, weight and waist circumference. These also detailed family and personal history, blood pressure, smoking and nutritional status and review of medication. An annual assessment of dental health had been completed. For those residents on antipsychotic medication an assessment of glucose regulation, blood lipids and prolactin levels were recorded.
- Referrals were made from the approved centre to specialist clinics for diabetes and vascular illness. Podiatry, ophthalmology, public health nurse, skin tissue viability, and palliative care services all came to the approved centre.

However:

- There was no evidence of assessments within the last year for any of the 10 ICP's reviewed. The ICP identified the resident's assessed needs for physical care but did not generally include psychosocial needs. A number had generic entries such as 'to optimize mental health'. Three residents' identified goals were not all appropriate and were not all reflective of those residents identified needs. Two of the ten inspected were deemed not to have identified the care and treatment required to meet the goals identified. Five of the ten ICP's inspected did not adequately identify the resources required.
- Appropriate psychosocial services and programmes were not being provided. Adequate and appropriate resources were not available to provide therapeutic services and programmes. There was no evidence of input from health and social care professionals such as social work or psychology. Only three occupational therapy sessions were scheduled per month.

Respect for residents' privacy, dignity and autonomy

- Each resident had a single bedroom. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Rooms were not overlooked by public areas and noticeboards did not display resident names or other identifiable information. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Residents were facilitated to make private phone calls.

- Residents' records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured.
- Physical restraint was carried out in compliance with the relevant code of practice.
- The approved centre was kept in a good state of repair both internally and externally. There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. The approved centre was clean, hygienic, and free from offensive odours.

However:

- It was noted that temperatures in some rooms were observed to be cold and excessively warm in other areas.

Responsiveness to residents' needs

- There was written information about the approved centre, mental health diagnoses and medication.
- There was a robust complaints procedure in place.
- Recreational activities were available for residents, both during the week and at the weekend. These included card games, a, newspaper group, bingo, movies, walks and outings. The approved centre had transport available for use by staff. Opportunities were provided for indoor and outdoor exercise and physical activity.
- Food was well presented and there was a choice at mealtimes.

Governance of the approved centre

- The approved centre was under the governance of the Mid West Mental Health Service Management team which included Limerick, Clare and North Tipperary. There was a local management team for Clare and North Tipperary region. There was an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the wider service.
- Service user representation was included in the governance structures with the area lead for mental health engagement on the Mid West Mental Health Service executive management team and the Clare North Tipperary management team.
- There was a programme of ongoing training and development in risk management. The approved centre inputted all risks into the National Incident Management System (NIMs) via the risk advisor.
- There was no system of performance appraisal for staff in the approved centre. Instead, performance issues were addressed through clinical supervision.
- Nursing staff conducted audit cycles.
- There was a wider service policy procedure and protocol group with sub groups working on various policies. These included membership of staff from the approved centre.

- The approved centre had commenced a Mental Health Commission CAPA Group meeting consisting of the Clinical Director and nursing staff since January to ensure compliance, which was intended to be held every two months.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Establishment of a smoke free campus committee to implement tobacco free campus.

2. Garden refurbishment programme with input from residents.

3. Onsite training of the Advancing Recovery in Ireland Education Service (ARIES) programme for staff.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Cappahard Lodge was located on the outskirts of Ennis town in a housing estate within its own courtyard. It had been operating as a psychiatry of later life and mental health rehabilitation approved centre since 2002. The sleeping accommodation comprised of 32 single rooms with 15 residents being accommodated during the course of the inspection.

The approve centre was in a good state of repair, clean and free from malodorous odours. Residents had access to two grassed garden, activity and therapy rooms, sitting rooms and adequate bathroom and toilet facilities.

There were two mental health teams in the approved centre; Rehabilitation and Recovery team (11 residents) and psychiatry of old age (four residents). Most of the residents had resided in the approved centre for a number of years. The focus on rehabilitation and recovery for the residents of the approved centre and the wider service was not evident by the lack of input from allied health professional in therapeutic services even though the majority of residents were under the care and treatment of the rehabilitation team.

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

Resident Profile	
Number of registered beds	***32***
Total number of residents	**15**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	15
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the collective governance of the Mid West Mental Health Service Management team, which encompassed counties Limerick, Clare and North Tipperary. The governance was managed locally by the Clare and North Tipperary management team.

The Mid-West Mental Health Services Management Team comprised of Directors of nursing, head of service, business manager, area lead for mental health engagement, and quality and safety risk advisor, met monthly. There was a Quality and Safety Meeting held monthly for the wider service, which also covered the approved

centre. The approved centre had commenced a Mental Health Commission CAPA Group meeting consisting of the Clinical Director and nursing staff since January to ensure compliance, which was intended to be held every two months.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place. Defined lines of responsibility were evident in each discipline. Each head of discipline met with staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the area management team. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments. No discipline had staff performance appraisals but all stated that this process was informally facilitated or addressed through supervision.

All heads of discipline had received training on clinical risk management and there was a programme of ongoing training and development in risk management. Each discipline maintained a risk register. The approved centre inputted all risks into the National Incident Management System (NIMs) via the risk advisor. Staffing shortages were an ongoing challenge that was mitigated for nursing with the use of overtime and agency staff.

Service user input was facilitated by engagement with the service user engagement lead. The advocate did not visit the unit, however details of IAN was displayed in the unit.

The Clinical Director emphasised that the approve centre focus on becoming a rehabilitation and recovery unit was very much in the forefront and discussion with the North Tipperary management team was ongoing. The inspectors were informed that the appointment of a Rehabilitation Consultant was imminent. Not all allied professionals were involved with therapeutic services in the approved centre; Occupational therapist was providing one hour sessions three out of four weeks.

There was a wider service policy procedure and protocol group with sub groups working on various policies. All policies were up to date and there was evidence of audit cycles, however it was noted that only nursing staff conducted the audits. The approved centre had a good emphasis on education and training.

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 (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 15: Individual Care Plan	✓		✗	Moderate	✓		✓		✗	High
Regulation 16: Therapeutic Services and Programmes	✓		✓		✓		✓		✗	High
Regulation 22: Premises	✓		✗	Moderate	✗	High	✗	Moderate	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing an Administration of Medicines	✓		✓		✓		✓		✗	Low
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	High

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

Regulation
Regulation 4: Identification of Residents
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 14: Care of the Dying
Regulation 18: Transfer of Residents
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 27: Maintenance of Records

4.3 Areas that were not applicable on this inspection

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

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.

No residents or family members engaged with the inspection team during the course of the inspection. However, there were informal engagement with residents.

There were no regular visits from the IAN but contacts details were displayed.

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
- Head of Service
- General Manager
- Service Manager
- Area Lead of Mental Health Engagement
- Principal Social Worker
- Director of Nursing
- Area Director of Nursing
- Acting Assistant Director of Nursing
- Clinical Nurse Manager 2

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 Clinical Director stated that mandatory training dates have been arranged for staff in the approved centre in the next few weeks.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs, including photograph, date of birth and MRN. The preferred identifiers to be used for each resident were detailed within the residents' clinical files. The identifiers used were person specific, and did not include room number or physical location, for example. Two appropriate resident identifiers were used when administering medication, medical investigations and providing other healthcare services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. In addition, an alert system was in place (orange sticker) for residents with the same or similar names.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Additionally, residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance, in order to maintain appetite and nutrition. There was a source of safe, fresh drinking water made available to residents at all times in easily accessible locations in the approved centre. Furthermore, hot meals were provided on a daily basis. However, for residents with special dietary requirements, there was no regular review of residents by a dietitian. Access to a dietetic service was through the primary care team if needed.

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 evidence of implementation pillar.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(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 January 2013. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: On inspection, it was found that appropriate hand-washing areas were provided for catering services, and there was also suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene standards in the approved centre were maintained to a requisite level to support food safety requirements. Food was adequately prepared in a manner that reduced the risk of contamination, spoilage, and infection. Furthermore, residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents in the approved centre were supported to keep and use personal clothing. Such clothing was clean and appropriate to the residents' needs. Emergency personal clothing was provided that was appropriate and took account of residents' preferences, dignity, bodily integrity, and religious and cultural practices.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Furthermore, secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property and possessions, as necessary. The resident was entitled to bring personal possessions with them, the extent of which would be agreed at admission. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This checklist was updated on an ongoing basis, in line with the approved centre's policy. With regard to this, there was clear individual documentation in relation to individual resident monies handled on behalf of the resident by staff. The access to and use of resident monies was overseen by two members of staff and the resident or their representatives.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 2019. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Information was provided to residents in an accessible format, which was appropriate to their individual needs, including the types and frequency of recreational activities available within the approved centre. Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of activities. Resident decisions on whether or not to participate were respected and documented. Opportunities were provided for indoor and outdoor exercise and physical activity. Communal areas were provided that were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the residents' clinical file.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2020. 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. There was an oratory located in the approved centre with an altar and religious texts, which facilitated residents' religious practices. There was also access for residents to multi-faith chaplains. There was a monthly mass in the approved centre and residents were supported to attend. Care and services that were provided within the approved centre were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were also clearly documented. Most residents in the approved centre refrained from religious practice, and this was facilitated accordingly.

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 in relation to visits. The policy was last reviewed in June 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed at the entrance of the approved centre on information leaflets. On inspection, visiting times were found to be appropriate and reasonable. A visiting area was provided at the entrance of the approved centre where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits, and children were accompanied at all times to ensure their safety. This was communicated to all relevant individuals publicly. Furthermore, the visiting room was suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Although no WiFi was available in the approved centre at the time of inspection, residents had access to mail, fax, e-mail, Internet, telephone, or any device for the sending or receiving of messages or goods unless otherwise risk-assessed with due regard to the resident' well-being, safety, and health. No resident had risks associated with external communication at the time of inspection. Furthermore, no resident had their incoming or outgoing communications examined.

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

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in May 2019. The policy did not address any of the requirements of the *Judgement Support Framework.* The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Evidence of Implementation: As there had been no searches in the approved centre since the last inspection, evidence of implementation was not assessed.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Excellent**

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

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in April 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of residents was protected, e.g. provision of a single room within the approved centre during the provision of end of life care. Representatives, family, next-of-kin, and friends were involved, supported, and accommodated during end of life care. The sudden death of a resident was managed in accordance with legal requirements.

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Ten ICPs were examined on inspection. The ICPs were a composite set of documents, and included space for goals, treatment, care, and resources required, as well as allocated space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Needs and goals had been rewritten or developed by nursing staff prior to the MDT meeting and brought to the meeting. As appropriate, residents and their families had been involved and included in the development of the goals. There was no evidence of assessments used by the allied health professionals within the last year, for any of the ICP's reviewed. The ICP identified the resident's assessed needs for physical care but did not generally include psychosocial needs. A number had generic entries such as 'to optimize mental health'. Three residents' identified goals were not all appropriate and were not all reflective of those residents identified needs. Two of the ten inspected were deemed not to have identified the care and treatment required to meet the goals identified. Furthermore, five of the ten ICP's inspected did not adequately identify the resources required. It was understood that these resources were primarily nursing staff.

A keyworker who was a member of the nursing team was identified to ensure continuity in the implementation of the individual care plan. The ICP included an individual risk management plan and

when appropriate a preliminary discharge plan. The ICP was reviewed at least once every six months with the MDT members present at the review. The documentation did not support full MDT involvement in the review.

The resident had access to their ICP and was kept informed of any changes. The resident was offered a copy of their ICP, including any reviews. This was documented. Where a resident declined or refused a copy of their ICP, this was recorded, including the reason if given.

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

a) **The care plans had not been updated by the resident's multi-disciplinary team.**
b) **Three of ten care plans reviewed did not specify appropriate goals for the resident.**
c) **Five of ten care plans did not adequately identify the resources required.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre was deemed not to be appropriate in meeting the needs of the residents. An occupational therapy group that had been held weekly had been decreased to three weeks in the month. Records showed that at the time of inspection this group had been facilitated for four of the previous eight weeks.

Therapeutic services and programmes were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. While a detailed programme of activities was available there were deemed to be mainly recreational in nature. The exception was the occupational therapy group. There was no evidence of any assessments having been completed within the last year to indicate or evidence that what was being provided was adequate to restore or maintain optimal levels of psychosocial functioning.

A list of all the activities provided in the approved centre was available to residents. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location; for example, both a seating occupational therapy assessment and a dietetic assessment were arranged through primary care. These related to physical care needs, identified in the ICP's. The concern noted by the inspector was that appropriate psychosocial services and programmes were not being provided, but neither were they being identified as assessed needs. Adequate and appropriate resources

were not available to provide therapeutic services and programmes. There was no evidence of input from other allied health professionals such as social work or psychology.

There were a number of different spaces and rooms available for groups and activities within the approved centre. These included a snoezelen / relaxation room. A record was maintained of participation and engagement in and outcomes achieved in the occupational therapy group. A record was also maintained for participation in the more general activities facilitated by nursing staff.

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

a) **The therapeutic services and programmes provided by the approved centre were not appropriate to the resident cohort. Only three occupational therapy sessions were scheduled per month. 16 (1).**
b) **The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of psychosocial functioning of residents, 16 (2).**

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A log of transfers was maintained. Each transfer record had 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 a resident who was transferred to another facility was examined on inspection. Communication records with the receiving facility were documented, including agreement of resident receipt prior to transfer. Documented consent of the resident to transfer was available or justification as to why consent was not received. Full and complete written information for the resident was transferred when they moved from the approved centre to another facility. Information was sent in advance the resident upon transfer, to the named individual.

The following was issued as part of the transfer documentation: a letter of referral, including a current list of medications; resident transfer form (triplicate book: one copy for the transferring facility, one for the clinical file and one remaining in the transfer book), and; the required medication for the resident during the transfer process. A checklist was completed by the approved centre to ensure that comprehensive resident records were transferred to the receiving facility. Furthermore, copies of all records relevant to the resident transfer were retained in the resident's clinical file. There was a separate section in the clinical file for the storing of this documentation.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED). Weekly checks were completed on both. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centres provision of care. Residents received appropriate general health care interventions in line with their individual care plans. Additionally, residents' general health needs were monitored and assessed as indicated by the residents' specific needs.

The six monthly general health assessment documented the following in the approved centre: physical examination; family and personal history; body-mass index (BMI), weight, and waist circumference; blood pressure; smoking status; nutritional status (diet and physical activity, including sedentary lifestyle, and; dental health. Three files were inspected for residents on antipsychotic medication, and all were assessed annually for the following (unless a more regular review was indicated by physical examination): glucose regulation (fasting glucose/HbA1c); blood lipids; ECG, and; prolactin.

Referrals were made from the approved centre to specialist clinics for diabetes and vascular illness. As well as the former, podiatry, ophthalmology, public health nurse, skin tissue viability, and palliative care services all came to the approved centre. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing, for example, lab results. Residents in the approved centre had access to national screening programmes that were available according to age and gender, including but not limited to breast check, retina check (diabetics only), and bowel screening. Information was also provided to residents regarding the national screening programmes available through the approved centre. Residents did not have access to smoking-cessation programmes or supports.

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 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission, including the approved centre's information booklet that detailed the care and services. This information booklet contained details of the following: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and; residents' rights. In addition, 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, provision of such information was prejudicial to the resident's physical or mental health, well-being, or emotional condition.

Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side effects. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included

information on indications for use of all medications to be administered to the resident, including any possible side-effects. The information in the documents provided by or within the approved centre was evidence-based. Residents had access to interpretation and translation services as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Residents in the approved centre were called by their preferred name, and the general demeanour of staff was found to be appropriate on inspection, as was the manner in which staff addressed and communicated with residents. Staff appearance and dress was also appropriate. Staff demonstrated discretion when discussing the resident's condition or treatment needs, and sought the resident's permission before entering their room, as appropriate. All residents wore clothes that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. Said locks were tested on the inspection walkabout. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas and, if so, were fitted opaque glass. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

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 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in September 2018. There was also a policy on ligature risk reduction, which had been last reviewed in June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Appropriately sized communal rooms were provided in the approved centre. Rooms were ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise/acoustics. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Most residents spend their time in the tea and coffee area which is somewhat cramped. Ligature points remain outstanding.
The approved centre was kept in a good state of repair both internally and externally. There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. Furthermore, the approved centre was clean, hygienic, and free from offensive odours. There was a sufficient number of toilets and showers for residents in the approved

centre. Such toilets were accessible, clearly marked, and close to day and dining areas. Toilet facilities were also wheelchair accessible and identified for use by both residents and visitors. The approved centre had a designated sluice room, cleaning room, and laundry room. It was noted that temperatures in some rooms were observed to be cold and excessively warm in other areas.

The approved centre also had a dedicated therapy/examination room. All resident bedrooms were appropriately sized to the address the resident needs. The approved centre provided suitable furnishings to support resident independence and comfort. Assisted devices and/or equipment was provided to address resident needs. Monitoring of remote or isolated areas of the approved centre took place.

The approved centre was non-compliant with this regulation because the approved centre was not adequately heated, as some rooms were observed to be cold, while others were excessively warm, 22 1 (b).

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: On inspection, ten random MPARs were reviewed. Three MPARS did not have micrograms written in full, and three MPARs did not have a full record of medication given. All entries on the MPAR were legible, and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition, and this was documented in the clinical file. A prescription was not altered where a change was required. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs (except those for self-administration), were administered by a registered nurse or registered medical practitioner.

Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident's pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration; expired medications were not administered. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. Where the resident refused the medication, this was documented in the MPAR and the clinical file, and communicated to medical staff. Schedule 2 controlled drugs were checked by two

members of staff (one of which was a registered nurse) against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book.

Medication was stored in the appropriate environment as indicated on the label or packaging, or as advised by the pharmacist. Medication storage areas were clean and free from damp, mould, litter, dust, pests, and from spillage or breakage. Food and drink was not stored in areas used for the storage of medication. Medication dispensed or supplied to the resident was stored securely in a locked storage unit (e.g. drugs trolley or drawers), with the exception of medication that was recommended to be stored elsewhere (e.g. refrigerator). The medication trolley and/or medication administration cupboard remained locked at all times and secured in a locked room. Schedule 2 and 3 controlled drugs were locked in a separate cupboard away from other medicinal products, to ensure further security.

The approved centre was non-compliant with this regulation because three MPARs did not have all records of medication administered, 23 (1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in June 2019. It also had an associated safety statement, dated June 2019. The policy and safety statement addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Raising awareness of residents and their visitors to infection control measures.
- Covering of cuts and abrasions.
- Availability of staff vaccinations and immunisations.
- Management and reporting of an infection outbreak.
- Support provided to staff following exposure to infectious diseases.
- Specific infection control measures in relation to infection types e.g. C. diff, MRSA, Norovirus.
- First aid response requirements.
- Falls prevention initiatives.

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements.
The policy was last reviewed in July 2017. The policy/policies and procedures did not address the following:

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

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels

recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: An appropriately qualified staff member was on duty and in charge at all times, and this was documented. This was implemented through the approved centre's duty roster. There was no written staffing plan in the approved centre. Where agency staff were used, there was a comprehensive contract between the approved centre and any registered or licenced staffing agency used that set out the agency's responsibilities in relation to the following: vetting of staff, including Garda vetting and references from other jurisdictions as appropriate; confirmation of registration or validation of status, where applicable; confirmation of identity; professional indemnity; confirmation of staff training, and; arrangements for responding to concerns/complaints.

All healthcare professionals were trained in the Mental Health Act 2001 and Children First. Additionally, they were trained in manual handling, infection control and prevention, including sharps, hand hygiene techniques, and use of personal protective equipment (PPE); dementia care; care for residents with an intellectual disability; end of life care; risk management – individual, organisational, and care and treatment provision as appropriate to the staff role; incident reporting, and; protection of children and vulnerable adults.

Not all healthcare professionals were trained in fire safety, Basic Life Support. All staff training was documented, and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Mgmt. of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (23)	16	69%	16	69%	22	95%	23	100%	23	100%
Medical (5)	2	40%	0	0%	1	20%	5	100%	5	100%
Occupational Therapist (3)	3	100%	1	33%	2	66%	3	100%	3	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%

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

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Assistant Director of Nursing	1 WTE (9-5)	
Clinical Nurse Manager 3	0	
Clinical Nurse Manager 2	2	
Registered Psychiatric Nurse	23	
Occupation Therapist	3	
Social Worker	1	
Psychologist	1	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
	CNM11	1	0
	RPN	5	3
	HCA	0	0
	Occupational Therapist	0.1	

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Occupation Therapist	3	
Social Worker	1	
Psychologist	1	

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

The approved centre was non-compliant with this regulation because not all staff were trained in fire safety, Basic Life Support 26 (4).

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

(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.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: All residents' records were secure, up-to-date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. All resident records were stored together, where possible. Resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence, and were maintained in good order, for example, no loose pages. Records were written legibly in black, indelible ink, and were readable when photocopied. Entries were

factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Each entry included the date, and time using the 24-hour clock, and was followed by a signature. Two appropriate resident identifiers were also recorded on all documentation. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre. Additionally, records were retained or destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in November 2018. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

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

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

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders (including service users), as appropriate. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines. Operating policies and procedures of the approved centre were communicated to all relevant staff, and were appropriately approved. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

The format of policies and procedures was standardised, and included: the title of the policy and procedure; reference number of the policy and procedure; the document owner; reviewers, where applicable; the scope of the policy and procedure; the date at which the policy will be implemented (effective from); scheduled review date – the document was re-dated after each review, and; the total number of pages in the policy and procedure. However, the format of operating policies and procedures did not include the document's approvers. Where generic policies (e.g. complaints, staffing, etc.) were used, the approved centre had a written statement to this effect (adopting the generic policy), which was

reviewed at least every three years. Generic policies used were appropriate to the approved centre and the resident group profile.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon.

Evidence of Implementation: There was a nominated person responsible for dealing will all complaints who was available to the approved centre. A consistent and standardised approach was implemented to the management of all complaints. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. This included the following: at admission through an information booklet; the complaints procedure, including how to contact the nominated person, was publicly displayed; contact details of the nominated person if not based in the approved centre, and; residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

All complaints, whether written or oral, were investigated promptly and handled appropriately and sensitively. Additionally, the registered proprietor ensured that the quality of service, care, and treatment, of a resident were not adversely affected by reason of a complaint being made. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. There were no outstanding complaints at the time of inspection, as they had been dealt with at a local level. Furthermore, at the time of inspection, there were several minor complaints that had been documented and closed out.

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 pillar.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

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

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Not all clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported, and monitored. Clinical risks were documented in the risk register, as appropriate. Both health and safety risks and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. The approve centre did not keep copies of incidents reports on the ward as they were sent to risk advisor for sign off. Structural risks, including ligature points, were removed of effectively mitigated.

The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing. Individual risk assessments were completed prior to and during the following: physical restraint; at admission to identify individual risk factors, including general health risks, risk of absconding, risk of self-harm etc.; resident transfer; resident discharge, and; in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation and review of the individual risk management process. Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting.

The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. 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. Furthermore, 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 training and education and evidence of implementation pillars.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had not been reviewed annually and was dated September 2018. It addressed the following:

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

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

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

Evidence of Implementation: On inspection, one clinical was examined in relation to physical restraint. It showed that physical restraint (PR) was used in rare, exceptional circumstances and in the best interests of the resident, where the resident posed a serious immediate threat of serious harm to self or others. PR was used only after all alternative interventions to manage the resident's unsafe behaviour had been considered. In addition, the episode of PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

PR was initiated by a registered medical practitioner (RMP), a registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. Staff were aware of relevant considerations in the individual care plan pertaining to the resident's requirements or needs in relation to the use of PR. The resident was informed of the reasons for, likely duration of, and circumstances leading to discontinuation of PR unless the information might be prejudicial to the resident's mental health, well-being, or emotional condition. Where practicable, same sex staff were present at all times during an episode of PR. Furthermore, the resident was afforded the opportunity to discuss the episode with members of the MDT involved in their care as soon as was practicable. Each episode of PR was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge, all of which were last reviewed in February 2018. Each policy included all of the policy related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: There had been no new admissions to the approved centre since the last inspection.

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

Discharge: No residents had been discharged from the approved centre since the last inspection.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001300		**The care plans had not been updated by the resident's multi-disciplinary team. Three of ten care plans reviewed did not specifiy appropriate goals for the resident. Five of ten care plans did not adequately identify the resourses required.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All care plans have been updated and have goals that are appropriate to each individual resident. The resources required to achieve these goals have now been identified. Training on ICP will commence in Cappahard on week commencing 9th November 2020. This training will be completed by Quarter 1 2021.	• 3 monthly audits • Refresher training to be provided to all staff on the process of completion of ICP's.	Realistic	31/03/2021	Clinical Director ADON Heads of Discipline CNMII CNM2 Aidan O'Neill ADON Barbara Morrissey
Preventative Action	Training on ICP will commence in Cappahard on week commencing 9th November 2020. This training will be completed by Quarter 1 2021. Staff aware of MHC guidance document	Records of training will be maintained.	Realistic	31/03/2021	Clinical Director ADON Heads of Discipline CNMII CNM2 Aidan O'Neill ADON Barbara Morrissey

	on individual care planning. Every resident has an six monthly date for MDT review of ICP (or more frequently if required) ICP's have been updated with individual needs, goals and actions individualised for each resident. Resources have been identified to achieve these goals.				

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10001294		The therapeutic services and programmes provided by the approved centre were not appropriate to the resident cohort. Only three occupational therapy sessions were scheduled per month. 16 (1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Review carried out and appropriate programmes identified and have commenced. (delayed previously due to Covid 19) Occupational Therapy Group has recommenced since the 31st August 2020, with one Occupational Therapy Session per week. The group will be open to all resident in the unit and will be occupational in focus, based on the identified means of the residents. Art Therapy to commence weekly sessions on 9th November 2020. Social Work and Clinical Psychology groups have	Audit of ICP	Realistic	31/08/2020	OT Manager and Clare North Tipp Mgt Team.

	commenced as per 100001295				
Preventative Action	Ongoing review by the Clare North Tipperary Mgt Team	Agenda Item on Clare North Tipperary Mgt Team	Realistic	31/08/2020	OT Manager
Reason ID : 10001295		**The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of psychosocial functioning of residents, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Review carried out (Social Work) and Recovery Orientated Group appropriate to residents needs is currently delivered by Social Worker Rehabilitation Team . (Previously delayed due to Covid 19) Psychology team have commenced a group " Minding your Mental Health as we Grow Older". This will provide therapeutic support to resident in managing issues related to declining health and aging. It is hoped also to support and help provide residents	Audit of ICP Service user feedback and analysis will be carried out by Social Worker, Psychology and CNM2.	Realistic	19/04/2021	Principal Social Worker & Psychology Service

	with stronger coping skills in response to aging.				
Preventative Action	Ongoing review by the Clare North Tipperary Mgt Team	Ongoing review by the Clare North Tipperary Mgt Team	Realistic	19/04/2021	Principal Social Worker & Psychology Service

Regulation 22: Premises					
Reason ID : 10001296		The approved centre was not adequately heated, as some rooms were observed to be cold, while others were excessively warm, 22 1 (b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Programme of works identified and Submitted to Maintenance Department, to be progressed. Further development works to be discussed with Maintenance Department and General Manager.	Identified on Quality Improvement Plan. 3 monthly review.	Realistic	31/10/2020	Technical Services; Assistant Director of Nursing; Clinical Nurse Manager II/ Service Manager
Preventative Action	The Technical Services team have serviced the boiler and heating system, the heating has now been regulated throughout the building. Please see attached programme of works. Monthly walk about unit with Technical Services. Ongoing review with Clare North Tipperary Management Team.	Analysis and Audit, Agenda Item for Management Team	Realistic	30/11/2020	CNM2/Techs Svs/Service Manager

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10001303		**Three MPARS did not have all records of medication administered, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff facilitated and prompted to complete On-line training. All staff to complete HSEland Medication management module.	All certificates of completion held by line managers.	Achievable	31/10/2020	CNMII, Clinical Director
Preventative Action	Monthly auditing through nursing metrics	Monitoring of audits by nurse management.	Achievable	31/10/2020	Nursing CNMII

Regulation 26: Staffing					
Reason ID : 10001304		Not all staff were trained in fire safety and Basic Life Support 26 (4).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	An updated 2020 training schedule has being developed incorporating all mandatory training. Staff facilitated and prompted to complete On-line training.	Update of training records 3 monthly by line mangers. Data inputted on training matrix. Review of educational and training needs yearly. Quarterly progress report forwarded to Mental Health Commission.	Achievable	31/10/2020	Heads of Discipline, Practice Development and Line Managers.
Preventative Action	3 monthly audit of mandatory training records by each head of discipline. Staff facilitated to attend/complete all mandatory training. On-going schedule of training available to staff.	Update of training records 3 monthly by Line Mangers.	Achievable	31/10/2020	Heads of Disciplines, Practice Development and Line Managers

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.

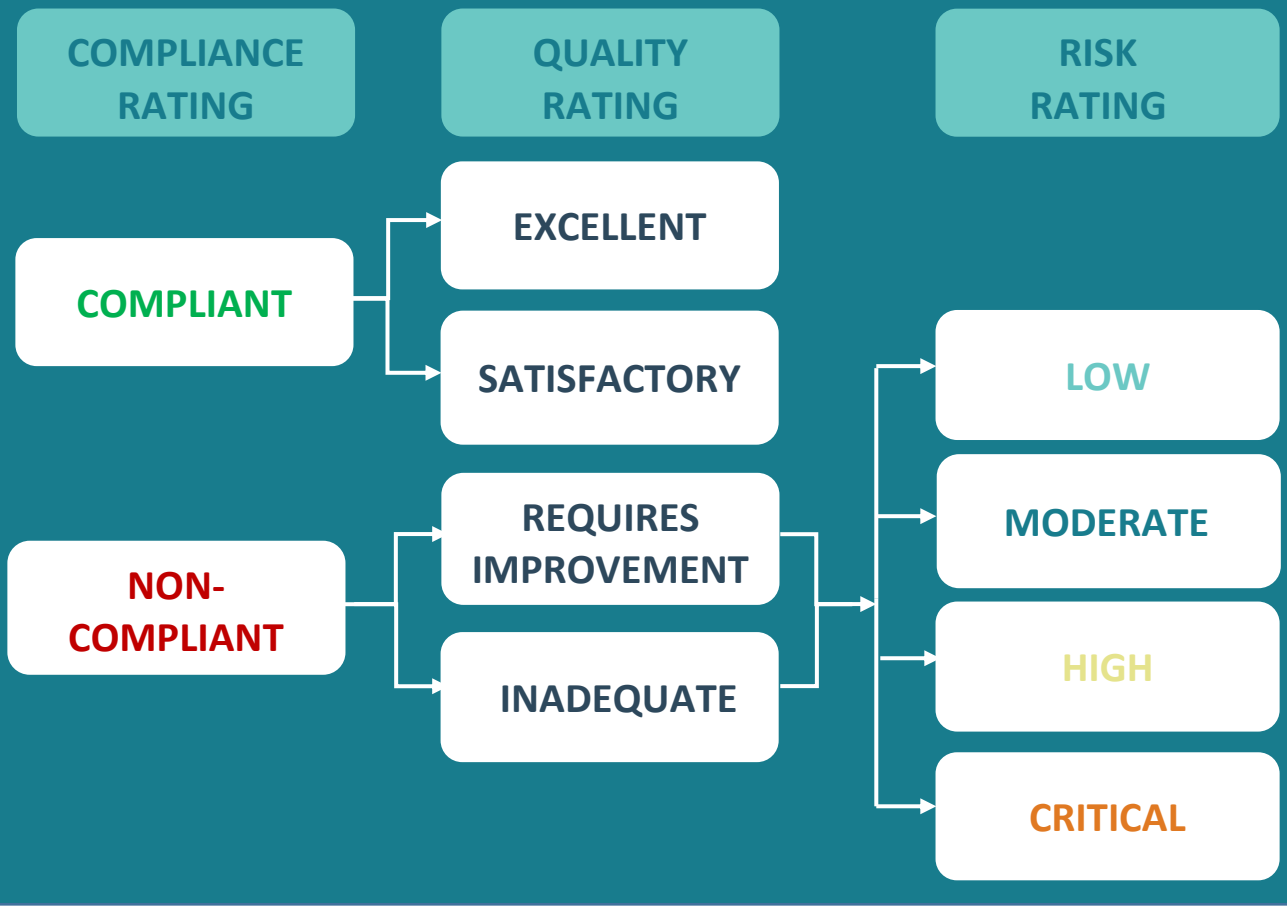
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, 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.

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
QUALITY RATINGS are generally given for all regulations, except for 28, 33 and 34.
RISK RATINGS are given for any area that is deemed non-compliant.



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.