MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Owenacurra Centre

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

OWENACURRA CENTRE

Owenacurra Centre, Midleton, Co. Cork

Date of Publication:
Thursday 10 December 2020

ID Number: AC0160

2020 Approved Centre Inspection Report (Mental Health Act 2001)

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

Most Recent Registration Date:
9th December 2019

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Kevin Morrison, General Manager Mental Health Services Cork Kerry Community Healthcare

Inspection Team:
Marianne Griffiths, Lead Inspector
Mary Connellan
Raj Ramasawmy

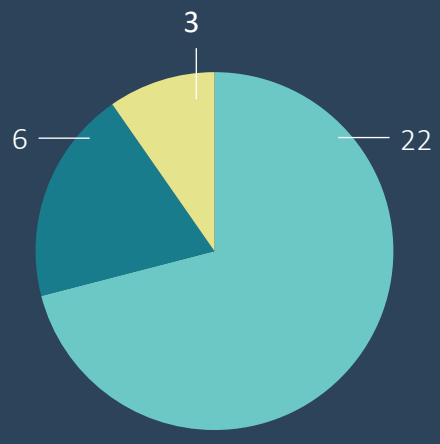
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
10 - 13 March 2020

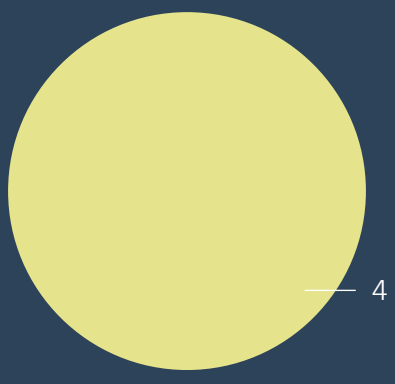
Previous Inspection Date:
30 April – 3 May 2019

Inspection Type:
Announced Annual Inspection

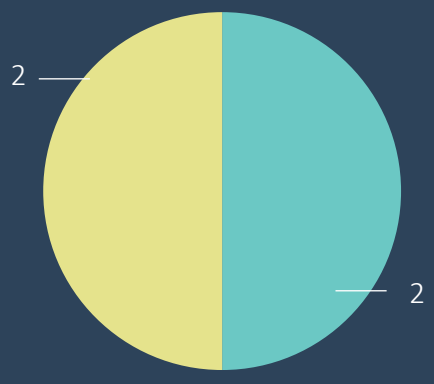
2020 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



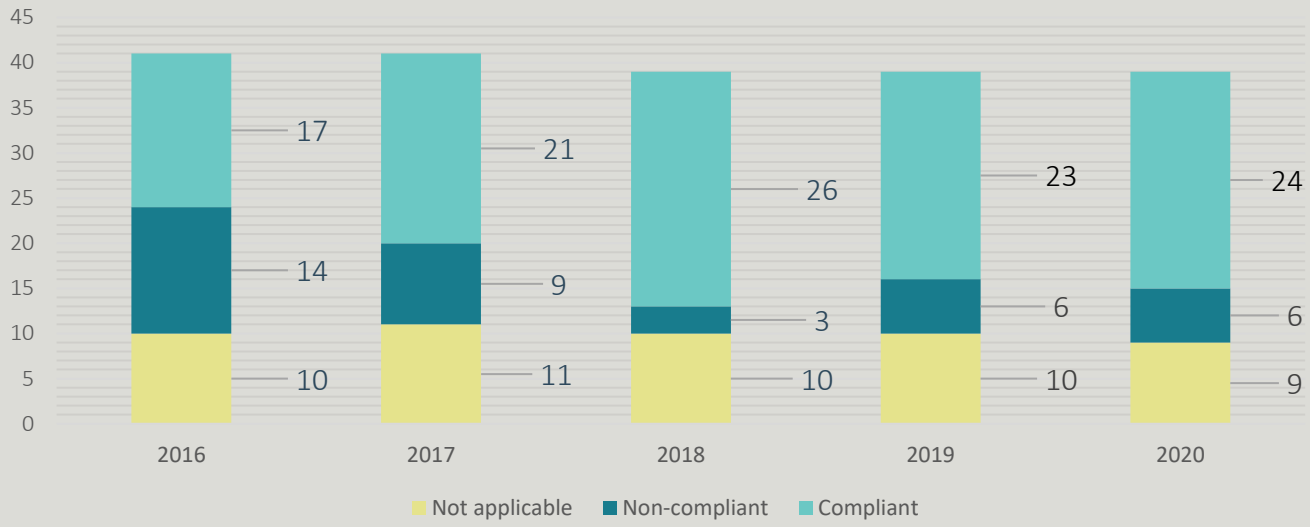
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2016 – 2020

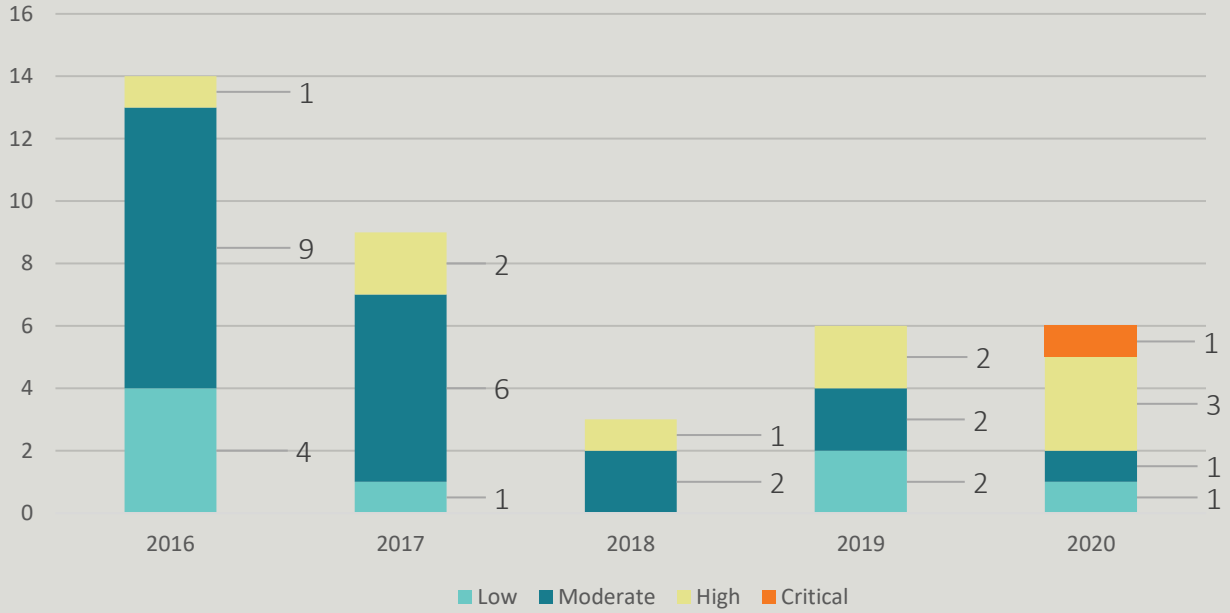
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The approved centre had 24 beds and provided long term care for residents. It was a single storey building constructed with a courtyard in the centre and located centrally in Midleton town. There were 4 double rooms and 16 single ones. The approved centre also included a day centre that was attended by both residents of Owenacurra and by non-residents from the community and catchment area.

The majority of residents were under the care of the General Adult team, and there were four rehabilitation beds. Two of the rehabilitation beds were reserved for residents who would attend for a short period of respite – normally one week at a time.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	55%	70%	90%	79%	80%
Regulations Rated Excellent	1	1	3	3	3

Conditions to registration

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

Safety in the approved centre

- Medication was ordered, prescribed, stored and administered in a safe manner.
- Regular food safety audits were carried out and kitchen areas were clean.
- All staff had completed mandatory training in fire safety, Basic Life Support, prevention and management of aggression and violence and the Mental Health Act 2001.

However:

- Hazards were not minimised in the approved centre: two hoists were stored in the corridor, a table and chairs were located outside of the clinical room making the corridor very narrow.

Appropriate care and treatment of residents

- Some nurse led activities took place in the approved centre, such as mindfulness practice, art, and music.
- Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six monthly general health assessments all documented: a physical examination; family and personal history; body mass-index, weight, and waist circumference; blood pressure, smoking status; nutritional status; a medication review, and; a dental health check.
- For residents on antipsychotic medication, there was a documented annual assessment of glucose regulation (Fasting glucose/HbA1c), blood lipids, and prolactin levels. The files examined on inspection included an annual ECG for each resident.

However:

- Ten individual care plans were examined.
    - In two of ten ICPs inspected, appropriate goals were not documented for the residents.
    - In two of ten cases, the ICP did not include the care and treatment required to meet the ICP goals.
    - Three ICPs did not identify the resources required.
    - In four cases, the ICPs were not reviewed by the MDT.
- The therapeutic services and programmes provided by the approved centre were not appropriate and did not meet the assessed needs of the residents, as documented in their individual care plans. Residents were not in receipt of an occupational therapy service. While social work and psychology were both available on a referral basis for one-to-one treatment, there were no social work or psychology led groups taking place in the approved centre.

Respect for residents' privacy, dignity and autonomy

- Residents were well connected to the community and regularly utilised the numerous amenities available in Midleton.
- All bathrooms, showers, and toilets had locks on the inside of the door. If a resident required a lock for their bedroom, this was facilitated. Where the resident shared a room, the bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not detail resident names or other identifiable information. Residents were facilitated to make private phone calls.
- A cleaning schedule was also in place; while the approved centre was generally clean, there was a malodour noted in the en suite bathroom of one bedroom.

However:

- The layout of the approved centre was not conducive to resident privacy and dignity due to the fact that both a day centre, which was open to the public, and health and social care offices were situated on the same corridor as resident bedrooms. This meant that members of the public and health professionals had access to the residents' sleeping area during the day.
- Bedrooms had good ventilation; however, one bathroom and one shower room were poorly ventilated. Corridors were not sufficiently lit and in six cases it was observed that light bulbs in resident rooms were broken. A strip light beside the oratory was also in need of replacement.
- Holes were observed in the wall of a storage room.
- Not all resident wardrobes were large enough to accommodate their belongings.

Responsiveness to residents' needs

- There were recreational activities in line with residents' preferences. Residents were free to go into the town.
- Information was available about the approved centre and residents' medications and diagnoses.
- There was a satisfactory complaints process.
- Food was nicely presented and there was a choice of food at mealtimes.

Governance of the approved centre

- Owenacurra Centre was part of North Lee Mental Health Services, Community Healthcare Organisation (CHO) Area 4. Owenacurra Head of Discipline meetings took place every two to three months and Owenacurra Centre was represented at the Cork Executive Management Team meetings, which took place every month.
- The North Lee Policy, Procedure and Processes Group met monthly to discuss and review policies as well as document the steps to be taken for their approval. All policies for the regulations had been reviewed within the past three years. Not all policies included the required processes and procedures of the Judgement Support Framework.
- Each Head of Discipline had received training in risk management and were aware of operational risks that faced their respective departments. The approved centre had a local risk register, which contained the risks identified in the approved centre. Risks that had been escalated to the area risk register were discussed at the North Lee Mental Health Services Quality and Safety Meetings, which took place every three months.
- Staff in the Owenacurra Centre had completed a suite of audits since the 2019 inspection. These were nurse led and were generally lacking in detail. With some exceptions, the audit criteria chosen for self-assessment were not appropriate, meaning there was little opportunity for results to emerge that could potentially improve the practices in place.
- All staff who worked in the approved centre had completed mandatory training as required by the Mental Health Commission.

- There was a system in place in order to respond to resident complaints. A representative from the Irish Advocacy Network regularly attended the approved centre to meet with residents. The difficulties around the delivery of multi-disciplinary care notwithstanding, there was a culture of patient centred support and advocacy evident in the Owenacurra Centre.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had established a Smoke Free Campus Committee with the aim of making the campus smoke free.

2. A revised induction booklet had been introduced in order to support the induction process for new staff.

3. A new shower had been installed on the unit and the shower room was redeveloped.

4. Electronic rostering had been introduced into the approved centre in order to improve the processes around staff rostering.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre provided long term care for residents and was located centrally in Midleton town. It was a single storey building constructed with a courtyard in the centre. There were 4 double rooms and 16 single ones. Residents were well connected to the community and regularly utilised the numerous amenities available in Midleton. The building presented as old and in need of some repairs. The approved centre also included a day centre that was attended by both residents of Owenacurra and by non-residents from the community and catchment area.

The majority of residents were under the care of the General Adult team, and there were four rehabilitation beds. Two of the rehabilitation beds were reserved for residents who would attend for a short period of respite – normally one week at a time. All residents were voluntary.

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

Resident Profile	
Number of registered beds	**24**
Total number of residents	**22**
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	20
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Owenacurra Centre was part of North Lee Mental Health Services, Community Healthcare Organisation (CHO) Area 4.

The Owenacurra Head of Discipline meetings took place every two to three months and were attended by the relevant disciplines including the allied health professionals. Issues discussed included the lack of staffing resources, particularly in relation to occupational therapy (OT). The progress of plans to reconfigure the Owenacurra Centre were consistently documented. Discussions pertaining to the availability of step down facilities within the CHO also took place at these meetings.

The Owenacurra Centre was represented at the Cork Executive Management Team meetings, which took place every month. These meetings addressed issues impacting Cork Mental Health Services at senior management level. The regular themes included: Mental Health Commission compliance, delayed discharges, finance matters and strategic priorities for the CHO. All disciplines were represented at the

Cork Executive Management team meetings as well as administrative management. The Mental Health Engagement Service were not represented at senior management level.

The North Lee Policy, Procedure and Processes Group met monthly to discuss and review policies as well as document the steps to be taken for their approval. All policies for the regulations had been reviewed within the past three years – the majority of which had a review dated December 2019. The policies covered the requirements of the Regulations, with the exception of Regulation 27, Maintenance of Records. Not all policies included the required processes and procedures of the Judgement Support Framework despite the fact that these were highlighted in the 2019 inspection report.

Representatives from the following disciplines were contacted in order to ascertain their input into the approved centre: medical, nursing, occupational therapy (OT), social work and psychology. Heads of discipline for each of the five specialties each returned a completed Mental Health Commission governance questionnaire. All heads of discipline attended the Owenacurra Centre on at least a monthly basis, if not more frequently. All met with their staff on a regular basis and had established reporting structures in place. Each had received training in risk management and were aware of operational risks that faced their respective departments. Supervision structures were in place; on a formal basis for medical, social work and psychology staff and on an informal basis for nursing. The systems of audit contributed to continuous quality improvement within Owenacurra. The occupational therapy manager confirmed the fact that there was no OT resource allocated to Owenacurra.

Staff in the Owenacurrra Centre had completed a suite of audits since the 2019 inspection. These were nurse led in their nature and, were generally lacking in detail. With some exceptions, the audit criteria chosen for self-assessment were not appropriate, meaning there was little opportunity for results to emerge that could potentially improve the practices in place.

There was a culture of incident reporting in the approved centre and the risk management processes appeared to manage risks as they were identified. The approved centre had a local risk register, which contained the risks identified in the approved centre. Risks such as the lack of occupational therapy staffing and the privacy issues presented by the building, had been escalated to the area risk register and were discussed at the North Lee Mental Health Services Quality and Safety Meetings, which took place every three months.

All staff who worked in the approved centre had completed mandatory training as required by the Mental Health Commission. The continued lack of occupational therapy input into the approved centre meant that the staff skill mix was not adequate to meet the needs of Owenacurra residents.

There was a system in place in order to respond to resident complaints. However, no complaints had been escalated to the complaints officer since the last inspection and all complaints made since then were considered minor in nature. A representative from the Irish Advocacy Network regularly attended the approved centre to meet with residents. The difficulties around the delivery of multi-disciplinary care notwithstanding, there was a culture of patient centred support and advocacy evident in the Owenacurra Centre.

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 Plans	X	Moderate	ü		ü		ü		X	Moderate
Regulation 16: Therapeutic Services and Programmes	ü		X	Moderate	ü		X	High	X	Critical
Regulation 21: Privacy	X	Moderate	ü		X	High	X	High	X	High
Regulation 22: Premises	X	Moderate	ü		X	Moderate	X	Low	X	High
Regulation 26: Staffing	X	Moderate	X	High	ü		X	Moderate	X	High
Regulation 27: Maintenance of Records	X	Moderate	X	Moderate	ü		X	Moderate	X	Low

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

4.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 7: Clothing
Regulation 14: Care of the Dying

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.

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

Four residents returned completed questionnaires. Responses were generally positive with all four stating that they received information about their care and treatment, that they knew who their multi-disciplinary care team were and that they had space for privacy. Two indicated that they were always involved in goal setting for their individual care plans, with two respondents ticking 'sometimes' for this question. All indicated that they were happy with how the staff spoke to them and that there were enough activities to do during the day.

The Irish Advocacy Network reported that residents enjoyed the Christmas celebrations on the unit. Residents told them that the staff were supportive and available. They stated that the proximity of the unit to Midelton town centre was an advantage and allowed access to community resources including evening classes.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Area Administrator
- Consultant Psychiatrist
- General Manager

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. There was a discussion about the status of the approved centre business cases submitted to the Department of Health for an OT post. Similarly, an update was provided to the inspectors about the application to develop the premises in order to rectify the privacy issues highlighted.

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 December 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 identifying residents, as set out in the policy.

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

Evidence of Implementation: The approved centre used a minimum of two resident identifiers that were appropriate to the resident group profile and individual residents' needs. The preferred identifiers used for each resident were detailed within the residents' clinical files. The identifiers were person specific and appropriate to the residents' communication abilities, and resident photographs were evident on the clinical files and MPARs.

Two appropriate resident identifiers were used when administering medication, medical investigations, and providing other healthcare services. There was a sticker alert system in place for the use of appropriate identifiers and alerts 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 December 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 food and nutrition, as set out in the policy.

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

Evidence of Implementation: Menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals and food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance, in order to maintain appetite and nutrition. Hot and cold drinks were offered regularly to residents.

There was a source of safe, fresh drinking water made available to residents at all times in easily accessible locations throughout the approved centre. Hot meals were provided on a daily basis.

The approved centre did not routinely implement an evidence-based nutrition assessment tool for residents. Weight charts were implemented, monitored and acted upon for residents, where appropriate. Nutritional and dietary needs were assessed, where necessary, and addressed in the resident's individual care plan. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(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 December 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 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 not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. Appropriate protective equipment (including Personal Protective Equipment (PPE), where required) was used during the catering process. There was suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food.

Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned. Food was prepared in a manner that reduced risk of contamination, spoilage, and infection. 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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 7: Clothing

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 December 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 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: Resident clothing was clean and appropriate to the residents' needs. Residents were supported to keep and use personal clothing. Residents were provided with emergency personal clothing that was appropriate to the resident and that considered their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of night clothes during day time hours, unless specified otherwise in their individual care plan. Each resident had an adequate supply of individualised clothing.

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 **Satisfactory**

(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 December 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the communications with the resident, and their representatives, regarding the resident's entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

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 not monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Resident's personal property and possessions were safeguarded when the approved centre assumed responsibility of them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. Residents were entitled to bring personal possessions with them, the extent of which was agreed at admission. The approved centre compiled a detailed property checklist with each resident on admission, detailing their personal property and possessions. The property checklist was kept separate to the resident's individual care plan and was available to the resident.

The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where any money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan, or in accordance with the approved centre's policy.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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 December 2019.

The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for determining resident needs, likes and dislikes in relation to activities.
- The process applied to risk assess residents for recreational activities, including outdoor activities.

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 and which took place on weekdays and weekends. Activities were provided by the unit nursing staff in the day centre, to which all Owenacurra residents had access. Information was provided to residents in an accessible format, which was appropriate to their individual needs. Individual risk assessments were completed for residents in relation to the selection of activities, where deemed appropriate.

The recreational activities provided by the approved centre were appropriately resourced and included music, bingo, art, and outings. Opportunities were provided for indoor and outdoor exercise and physical activity. Communal areas were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the resident's clinical file, as appropriate.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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 December 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities in relation to the support of residents' religious practices.

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. Residents had access to multi-faith chaplains as required. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment.

There were facilities provided within the approved centre for residents' religious practices, insofar as was practicable. Care and services 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 clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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 pillar.

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

(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 December 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the availability of appropriate locations for resident visits.

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

Monitoring: Documented analysis had not been completed to identify opportunities for improving visiting processes.

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

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

(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 December 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process to be followed in order to assess resident communication needs.

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

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

Evidence of Implementation: Residents had access to mail, fax, email, internet, telephone, or any device for the purposes of sending or receiving messages or goods unless otherwise risk assessed with due regard to the residents' wellbeing, safety, and health.

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 pillar.

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 December 2019.

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.

As no searches had been carried out since the 2019 inspection, this regulation was only assessed against the processes and training and education pillars.

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 December 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 end of life care, as set out in the policy.

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

Evidence of Implementation: The clinical file of one resident who had died in the approved centre was examined on inspection. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs: this was documented in the resident's individual care plan. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of residents was protected, including the allocation 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. Pain management was prioritised during end of life care and support was given to other residents and staff following a resident's death.

All resident deaths in the approved centre, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death occurring.

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 MODERATE

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 December 2019. The policy included all any 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. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Documented analysis had completed to identify ways of improving the individual care planning process.

Evidence of Implementation: The individual care plan was a composite set of documents. It was stored in the clinical file, was identifiable and uninterrupted and was not amalgamated with progress notes. In total, ten ICPs were examined on inspection. While the majority of residents had been in the approved centre for a number of years, the files indicated that each resident was initially assessed at admission. An initial care plan was completed by the admitting clinician to address the immediate needs of the resident. An initial assessment was also completed, and included: medical, psychiatric, and psychosocial history; medication history and current medications; a current physical health assessment, and; a detailed risk assessment.

Evidence-based assessments were used where possible. The individual care plan was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next-of-kin, as appropriate. All individual care plans inspected identified the residents' assessed needs.

However, in two cases the individual care plan did not identify appropriate goals for the resident. Similarly, in two ICPs the individual care plan did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. In three cases, the ICPs did not specify the resources required in order to provide the care and treatment. All ICPs included a risk management plan and the ICPs were reviewed on a six monthly basis. Four of the ten ICPs examined were not reviewed by the multi-disciplinary team.

Residents had access to their ICPs and were kept informed of any changes. In nine cases, there was documentation to indicate that the resident had been offered a copy of their ICP; however, this was not documented in one case, and the reason for this omission was not recorded.

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

a) **In two of ten ICPs inspected, appropriate goals were not documented for the residents.**
b) **In two of ten cases, the ICP did not include the care and treatment required to meet the ICP goals.**
c) **Three ICPs did not identify the resources required.**
d) **In four cases, the ICPs were not reviewed by the MDT.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating CRITICAL

(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 December 2019.

The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were not appropriate and did not meet the assessed needs of the residents, as documented in their individual care plans. Prior to Christmas, an occupational therapist had been working with the residents of the approved centre for five hours per week. This had allowed the facilitation of the Stepping Stones programme, an occupational therapy (OT) led rehabilitation programme that focused upon skills development. However, the five hours of occupational therapy treatment had been discontinued and, as a result, the residents were not in receipt of an OT service. While social work and psychology were both available on a referral basis for one-to-one treatment, there were no social work or psychology led groups taking place in the approved centre. The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning.

Some nurse led activities took place in the approved centre, such as mindfulness practice, art, and music. The nurse led therapeutic services and programmes provided by the approved centre were evidence-based and a list of these was available to the residents. Adequate and appropriate resources and facilities were available to provide nurse led therapeutic services and programmes.

The approved centre was non- compliant with this regulation in 2019, risk rated high.

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

a) **The approved centre did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with their individual care plan, 16 (1).**
b) **The approved centre did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, 16 (2).**

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the transfer of residents. The policy was last reviewed in December 2019. The policy addressed all requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The file of one resident who had been transferred out of the approved centre was examined. Communication records with the receiving facility were documented and available on inspection, including the agreement of resident receipt prior to transfer. Verbal communication and liaison took place between the approved centre and the receiving facility prior to the transfer itself. These included a discussion of the reasons for transfer. Resident requirements with regards to their accompaniment on transfer were not documented in the clinical file.

Documented consent of the resident to transfer was available. An assessment of the resident was completed prior to transfer, including an individual risk assessment relating to the transfer and the resident's needs. This was documented and provided to the receiving facility. However, the residents' accompaniment requirements on transfer were not documented.

Full and complete written information regarding the resident was transferred when the resident moved from an approved centre to another facility, including a letter of referral that detailed a list of current medications, and the resident transfer form. This information accompanied the resident upon transfer. A checklist was completed by the approved centre to ensure comprehensive resident records had been transferred to the receiving facility. Copies of all records relevant to the resident transfer process were retained in the resident's clinical file.

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

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 a policy in relation to the provision of general health services and the response to medical emergencies. The general health policy including the processes for managing medical emergencies was last reviewed in December 2019. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the provision of general health services to residents.
- The resource requirements for general health services including equipment needs.

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 policy.

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 not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency bag and staff had access at all times to an AED. Weekly checks were completed on the resuscitation bag and on the AED. Records were available of any medical emergency that occurred within the approved centre and the care implemented.

Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with their individual care plans. The files of five residents who had been in the approved centre for over six months were inspected. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The six monthly general health assessments all documented: a physical examination; family and personal history; body mass-index, weight, and waist circumference; blood pressure, smoking status; nutritional status; a medication review, and; a dental health check.

For residents on antipsychotic medication, there was a documented annual assessment of glucose regulation (Fasting glucose / HbA1c), blood lipids, and prolactin levels. The files examined on inspection included an annual ECG for each resident. Adequate arrangements were in place for access by residents

to general health services and for their referral to other health services as required. Residents had access to national screening programmes that were available according to age and gender, including Breast Check, cervical screening, retinal check, and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

(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 December 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the advocacy arrangements.

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. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre's Information Booklet that detailed the care and services provided. The booklet was available in the required formats to support resident needs and information was clearly and simply written. The booklet contained: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; designated visiting times and arrangements; details of relevant advocacy and voluntary agencies, and; a description of the approved centre's multi-disciplinary teams.

Residents were provided with written and verbal information regarding their diagnosis, unless in the resident's psychiatrist's view the provision of such information was prejudicial to the resident's physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident's diagnosis was documented in their clinical file. Information was provided to the resident 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 that was appropriate to the resident's needs. The content of the medication information sheets included information on indications for use of all medications to be administered to the resident, including any

possible side-effects. The information in the documents provided by, or within, the approved centre was evidence-based and were appropriately reviewed and approved prior to use. Residents had access to interpretation and translation services as required.

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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 December 2019.

The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.
- The approved centre's process to be applied where resident privacy and dignity is not respected by staff.

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

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

Evidence of Implementation: The general demeanour of staff and the manner in which staff addressed and communicated with residents was conducive to maintaining resident privacy and dignity. Staff discretion was displayed when discussing the resident's condition or treatment needs and staff sought the resident's permission before entering their room, as appropriate. All residents were wearing clothes that respected their privacy and dignity, e.g. no soiled clothing, inappropriate size or type of emergency clothing. Residents were called by their preferred name.

The layout of the approved centre was not conducive to resident privacy and dignity due to the fact that both a day centre, which was open to the public, and allied health professional offices were situated on the same corridor as resident bedrooms. This meant that members of the public and allied health professionals had access to the residents' sleeping area during the day.

All bathrooms, showers, and toilets had locks on the inside of the door. If a resident required a lock for their bedroom, this was facilitated. Where the resident shared a room, the bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not detail resident names or other identifiable information. Residents were facilitated to make private phone calls.

A service provided to day patients and allied health professional offices were located beside one of the Owenacurra dormitory corridors; therefore, the approved centre was non-compliant with this regulation because the layout of the approved centre premises did not ensure that resident privacy and dignity was respected at all times, 21.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 December 2019. The policy addressed requirements of the *Judgement Support Framework* with the exception of the approved centre's utility controls and requirements.

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 not been completed to identify opportunities for improving the premises.

Evidence of Implementation: The Owenacurra Centre was built in a square shape around an internal garden. Residents had access to personal space and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Bedrooms had good ventilation; however, one bathroom and one shower room were poorly ventilated. Corridors were not sufficiently lit and in six cases it was observed that light bulbs in resident rooms were broken. A strip light beside the oratory was also in need of replacement.

Sufficient space was provided to allow residents to move about. Hazards were not minimised in the approved centre: two hoists were stored in the corridor, a table and chairs were located outside of the clinical room making the corridor very narrow, and an unused bin was kept in one of the shower rooms. The approved centre was not kept in a good state of repair and some holes were observed in the wall of a storage room. There was a programme in place for general maintenance and decorative maintenance. A cleaning schedule was also in place; however, there was no programme for the repair of assistive

equipment. While the approved centre was generally clean, there was a malodour observed in the en suite bathroom of one bedroom. Not all resident wardrobes were large enough to accommodate their belongings. One corridor within the approved centre was poorly lit.

Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed and back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. Toilets were accessible and clearly marked and were close to day and dining areas. The approved centre did not have designated sluice room. The approved centre had a designated cleaning room, laundry room, and a dedicated therapy room. All resident bedrooms were appropriately sized to their specific needs. The approved centre provided suitable furnishings to support resident independence and comfort. The approved centre provided assisted devices and equipment to address resident needs.

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

a) **A malodour was evident in the en suite bathroom of one bedroom 22(1)(a).**
b) **One bathroom and one shower room was poorly ventilated, 22(1)(b).**
c) **One corridor within the approved centre was poorly lit, 22 (1)(b).**
d) **Corridors were poorly lit, light bulbs were broken and one strip light was not functioning 22(1)(b).**
e) **The provision of wardrobes that did not meet the needs of the residents meant that the approved centre did not consistently provide adequate and suitable furnishings, (22)(2).**
f) **The overall approved centre environment was not maintained with due regard to the specific needs of the residents: items such as hoists, an unused bin, and a table and chair located in the corridor were all potential trip hazards, 22(4).**

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

COMPLIANT

Quality Rating **Satisfactory**

(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 December 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 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 undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten Medication Prescription Administration records (MPARS) were inspected. All contained two appropriate resident identifiers and a record of any allergies or sensitivities to any medications, including if the resident had no allergies. The generic name of the medication and preparation was consistently documented.

The names of medications and preparations were written in full and there was dedicated space for routine medications and once-off medications. The frequency of administration, including the minimum dose interval for “as required” (PRN) medication, was documented correctly in all cases, as was the dose to be given. A record of all medications administered to the resident was maintained in the MPARs. For each medication there was a clear record of the date of its initiation and discontinuation. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was included in the MPARS. The signature of the medical practitioner was also included on each prescription.

All entries on the MPAR were legible and written in black indelible ink. Medication was reviewed and re-written at least six-monthly, or more frequently, where there was a significant change in the resident’s care or condition. Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by that 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. Good hand hygiene techniques were implemented during the dispensing of medications.

When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file.

Schedule 2 controlled drugs were checked by two staff members (one of whom was a registered nurse) against the delivery form and details were entered on the controlled drug book. The controlled drug balance available corresponded with the balance recorded in the controlled drug book.

Medication was not consistently stored in the appropriate environment as indicated on the label or packaging of the medication, or as advised by the pharmacist; some medications were kept in separate paper bags within the medication cabinet. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were clean and free from damp, mould, litter, dust, pests, and from spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules. Food and drink was not stored in areas used for the storage of medication.

Medication dispensed or supplied to the resident was stored securely in a locked cupboard, with the exception of medication which was recommended to be stored elsewhere (e.g. refrigerator). Some medication was kept in the medication storage trolley. Both the medication administration cupboard and the trolley remained locked at all times and secured in a locked room. Schedule 2 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

A system of stock-rotation was implemented to avoid accumulation of old stock. Medications that were no longer required, which were past their expiry date or have been dispensed to a resident but were no longer required were stored in a secure manner (in a separate locked box), segregated from other medication, and were returned to the pharmacy for disposal.

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

Regulation 24: Health and Safety

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 December 2019. It also had an associated safety statement, dated December 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.
- Management of spillages.
- First Aid response requirements.
- Vehicle controls.

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 December 2019. The policy addressed the following requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the following:

- The staff rota details and the methods applied for their communication to staff.
- The process for transferring responsibility from one staff member to another.
- 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 not reviewed on an annual basis. The numbers and skill mix of staff had not been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre's staff. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was

maintained in the approved centre. The numbers and skill mix of staffing was not sufficient to meet resident needs as the residents did not occupational therapy input.

Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment. All staff, including permanent and contract, were vetted in accordance with the approved centre's recruitment, selection and appointment policy and procedure. Information from referees was sought and documented. Staff had the appropriate qualifications to do their job. An appropriately qualified staff member was on duty and in charge at all times. The approved centre did not have a written staffing plan.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation training and induction training were completed for staff. All healthcare professionals were trained in Fire safety, Basic Life Support, the management of violence and aggression, as well as the Mental Health Act 2001 and Children First. Staff were trained in accordance with the assessed needs of the resident group profile and assessed needs of individual residents, as detailed in the staff training plan. Training included manual handing, infection control and prevention, risk management, recovery-centred approaches to mental healthcare and treatment, and Incident reporting.

All staff training was documented and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff and were supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained and competent individuals. There were facilities and equipment available for staff in-service education and training. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were made 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 (18)	18	100%	18	100%	18	100%	18	100%	18	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%	2	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%
Nursing (18)	18	100%	18	100%	18	100%	18	100%	18	100%

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

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Owenacurra	ADON	1	
	CNM2	1	0
	RPN	3	2
	Activity Nurse	2	0
	Social Worker	0.2	

In-reach to Approved Centre*			
	Staff Grade	**Day**	**Night**
Owenacurra	NCHD	Twice weekly	
	Psychologist	On a referral basis	
	Consultant Psychiatrist	Once weekly	

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 the absence of an occupational therapist in the approved centre meant that the staff skill mix was not appropriate to the assessed needs of the residents 26,(2).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating LOW

(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 December 2019. The policy addressed the following requirements of the *Judgement Support Framework*:

- The roles and responsibilities for retention of, and destruction of records.
- Record retention periods.
- The destruction of records.
- General safety and security measures in relation to records (stored in locked room or press).
- Retention of inspection reports relating to food safety, health and safety and fire inspections.

The policy did not address the following:

- The process for the creation of and access to resident records.
- The roles and responsibilities for the creation of and access to resident records.
- General safety and security measures in relation to records (stored in locked room or press).
- Retention of inspection reports relating to food safety, health and safety and fire inspections.
- The records required to be created for each resident.
- The required content for each resident record.
- Those authorised to access and make entries in the residents' records.
- Record review requirements.
- Privacy and confidentiality of resident record and content.
- Residents' access to their records.
- The relevant legislative requirements relating to record maintenance; the implementation of the Data Protection Acts, Freedom of Information Acts and associated controls for records.
- How entries in the residents' records are made, corrected and overwritten.
- The process for making a retrospective entry into resident 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 physically stored together, within the approved centre. A record was initiated for every resident assessed or provided with care and/or services by the approved centre. Resident records were reflective of the residents' current status and the care and treatment being provided. Each record was maintained through the use of an identifier that was unique to the resident, or some other effective method.

Resident records were developed and maintained in a logical sequence and in good order with, for example, no loose pages. Resident records were accessible to authorised staff only. Staff had access to the data and information needed to carry out their job responsibilities. Residents' access to their records was managed in accordance to the Data Protection Acts. Only authorised staff made entries in residents' records, or specific sections therein. Resident records were maintained appropriately. Records were written legibly in black, indelible ink and were readable when photocopied. Entries were factual, consistent, accurate, and did not contain jargon, unapproved abbreviations or meaningless phrases, and all included the date.

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

The approved centre was non-compliant with this regulation because the policy did not include the process for the creation of and access to resident records, 27, (2).

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 December 2019. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

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

The approved centre had an up-to-date policy for each of the regulations requiring a three year review. The format of policies and procedures was standardised and included: the title of the policy and procedure; the reference number and revision of the policy and procedure; the document owner, approvers, and reviewers; the scope of the policy and procedure; the date from which the policy will be implemented, and; the scheduled review date.

The policy format did not include the total number of pages in the policy and procedure. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

The approved centre was compliant with this regulation. The quality assessment was rated 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, monitoring and evidence of implementation pillars.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: As there had been no complaints made in the approved centre since the 2019 inspection this pillar was non-applicable.

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

The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. It included the provision of information about the complaints procedure to the resident and their representative at admission or soon thereafter, and the complaints procedure, including how to contact the nominated person, was publicly displayed.

No complaints, minor or major, had been made to the approved centre since the 2019 inspection.

The approved centre was compliant with this regulation.

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 December 2019. The policy addressed the following requirements of the *Judgement Support Framework*:

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

The policy did not address the following aspects of the Judgement Support Framework:

- The responsibilities of the multi-disciplinary team.
- The person responsible for the completion of six-monthly incident summary reports
- Organisational risks
- Capacity risks relating to the number of residents in the approved centre.
- Risks to the resident group during the provision of general care and services.
- Risks to individual residents during the delivery of individualised care.

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

Monitoring: The risk register was not reviewed quarterly to determine compliance with the approved centre's risk management policy; instead, it was reviewed annually. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: Responsibilities were allocated at management level and throughout the approved centre to ensure their effective 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. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation. Structural risks, including ligature points, were removed or effectively mitigated. All risks identified were documented in the risk register as appropriate. Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconsion, and risk of self-harm. Risk assessments were also documented for resident transfer, 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 processes. Residents were also involved in the individual risk management processes.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. 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. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education and monitoring 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. The certificate was displayed prominently opposite the entrance to 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 been reviewed annually and was dated December 2019. It addressed the following:

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

As there had been no physical restraint used in the approved centre since the 2019 inspection, this Code of Practice was only inspected against the processes and training and education pillars.

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.

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

Transfer: The transfer policy, which was last reviewed in December 2019, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2019, 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: The file of one resident was examined on inspection in relation to the admission process. The file indicated that the resident was admitted on the basis of a mental illness or mental disorder. An admission assessment was completed. This included a description of the presenting problem, past psychiatric history, medical history, current and historic medication, and a risk assessment. A full physical examination was also documented as part of the admission.

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

Discharge: The file of a discharged resident was also examined as part of the inspection. Prior to discharge, a meeting was held in order to plan the discharge. This was attended by the resident, their key worker, and relevant members of the multi-disciplinary team. A discharge assessment was documented. This included the residents' psychiatric and psychological needs, a current mental state exam, and a comprehensive risk assessment. Documented communication with the relevant primary care team was maintained in the clinical file. A comprehensive discharge summary was issued within 14 days as required and a follow up appointment was scheduled.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001330		**In two of ten ICPs inspected, appropriate goals were not documented for the residents. In two of ten cases, the ICP did not include the care and treatment required to meet the ICP goals. Three ICPs did not identify the resources required.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	MDT review of ICP process and documentation	Quarterly audit	Achievable	12/10/2020	Multi-disciplinary team
Preventative Action	Quarterly audit to monitor same	Quarterly audit	Achievable	12/10/2020	Multi-disciplinary team
Reason ID : 10001333		**In four cases, the ICPs were not reviewed by the MDT.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The current Occupational Therapy resourcing is currently under review by Management. Funding has been sought.	Ongoing engagement with Management.	OT resource is dependent on funding	31/12/2020	Head of Mental Health and A/Area
Preventative Action	All Heads of Disciple to remind staff to ensure that they attend the ICP meetings.	Memo from heads of discipline to relevant MDT staff	Achievable	12/10/2020	Local Management Team

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10001320		**The approved centre did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with their individual care plan, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	0.5 Occupational Therapist approved by Head of Service. Occupational Therapist will facilitate recommencement of suitable Occupational Therapy programmes in conjunction with client and ICP plans	recruitment process to commence	Contingent on current recruitment process and existing panel	31/12/2020	A/Area Administrator
Preventative Action	Nursing groups are taking place but due to Covid19 restrictions these are limited.	recruitment process to commence	Contingent on current recruitment process and existing panel	31/12/2020	A/Area Administrator
Reason ID : 10001321		**The approved centre did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	0.5 Occupational Therapist approved by Head of Service. Occupational Therapist will facilitate recommencement of suitable Occupational Therapy programmes	recruitment process to commence	Contingent on current recruitment process and existing panel	31/12/2020	A/Area Administrator

	in conjunction with client and ICP plans.				
Preventative Action	Nursing groups are taking place but due to Covid19 restrictions these are limited	recruitment process to commence	Contingent on current recruitment process and existing panel	31/12/2020	A/Area Administrator

Regulation 21: Privacy					
Reason ID : 10001334		A service provided to day patients and allied health professional offices were located beside one of the Owenacurra dormitory corridors; therefore, the approved centre was non-compliant with this regulation because the layout of the approved centre premises did not ensure that resident privacy and dignity was respected at all times, 21.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Management have had ongoing engagement with the Estates Department in relation to providing a revised costing for refurbishment. Capital funding approved. Estates engaging with design team to progress. Asbestos survey to assist with design detail approved and awaited. Overall project has been costed, detailed drawing is attached as a supporting document	Ongoing engagement with Estates Dept	achievable	31/03/2021	A/Area Administrator
Preventative Action	Non-residents and/or outpatients who attend services within the centre will be met on entry to the centre and	Ongoing communication with staff	Achievable and realistic	04/09/2020	ADON

	escorted to the relevant service.				

Regulation 22: Premises					
Reason ID : 10001323		**A malodour was evident in the en suite bathroom of one bedroom 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In addition to daily cleaning, the 4 bathrooms are now deep cleaned quarterly.	Complete	Complete - Quarterly audit to commence 01.10.2020	04/09/2020	ADON and Maintenance Department
Preventative Action	Quarterly Premises audit to include cleanliness audit.	Audit results	Achievable	10/10/2020	ADON and Maintenance Department
Reason ID : 10001324		**One bathroom and one shower room was poorly ventilated, 22(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New fans have been installed in the bathroom and shower room	Complete	Complete - Quarterly audits to commence on 01.10.2020	04/09/2020	ADON and Maintenance Department
Preventative Action	Quarterly Premises audit to identify any required maintenance.	Audit results	Achievable	01/10/2020	ADON and Maintenance Department
Reason ID : 10001325		**One corridor within the approved centre was poorly lit, 22 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All lighting has been changed to LED lighting.	Complete	Complete - quarterly audit to commence on 01.10.2020	04/09/2020	ADON and Maintenance Department
Preventative Action	Quarterly Premises audit to identify any required maintenance.	Audit results	Achievable	01/10/2020	ADON and Maintenance Department

Reason ID : 10001326		The overall approved centre environment was not maintained with due regard to the specific needs of the residents: items such as hoists, an unused bin, and a table and chair located in the corridor were all potential trip hazards, 22(4).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The corridor has been cleared. Laundry bins and hoists have been moved to another location. Table has been removed.	Complete	Complete	04/09/2020	Local Management Team
Preventative Action	All staff have been reminded of the need to remove all potential trip hazards to minimise the risk of falls. HSE Falls Policy currently being finalised.	Ongoing communication with staff.	Achievable	01/10/2020	Local Management Team
Reason ID : 10001327		**Corridors were poorly lit, light bulbs were broken and one strip light was not functioning 22(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All lighting has been changed to LED lighting.	Complete	Complete	04/09/2020	ADON and Maintenance Department
Preventative Action	Quarterly Premises audit to identify any required maintenance.	Audit results	Achievable	01/10/2020	ADON and Maintenance Department
Reason ID : 10001328		**The provision of wardrobes that did not meet the needs of the residents meant that the approved centre did not consistently provide adequate and suitable furnishings, (22)(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Carpenter commissioned to reconfigure the wardrobes in the four double rooms by the end of November 2020. Carpenter commissioned to create purpose built units in the laundry room to allow extra storage of surplus clothing by the end of November 2020. Residents will have identified areas to store surplus personal clothing.	On-going communication with the Maintenance Department	Achievable	30/11/2020	ADON
Preventative Action	Biannual clothing audit is undertaken.	Audit results	Achievable	30/11/2020	ADON

Regulation 26: Staffing					
Reason ID : 10001336		The absence of an occupational therapist in the approved centre meant that the staff skill mix was not appropriate to the assessed needs of the residents 26,(2).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The current Occupational Therapy resourcing is currently under review by Management. Funding has been sought.	Ongoing engagement with Management	OT resource is dependant on funding approval	31/12/2020	Area Administrator and A/Head of Mental Health Services
Preventative Action	A business plan for occupational therapy resource has been submitted and this is matter is discussed at head of discipline meetings	Ongoing engagement with Management	OT resource is dependant on funding approval	31/12/2020	Area Administrator and A/Head of Mental Health Services

Regulation 27: Maintenance of Records					
Reason ID : 10001337		**The policy did not include the process for the creation of and access to resident records, 27, (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A new policy has been created which address the creation and access to resident records. The policy will be implemented from 1st Sept 2020	Complete	Achievable	01/09/2020	Local Management Team
Preventative Action	All staff will be required to confirm in writing that they have read and understood the policy and agree to adhere to same	Staff will sign the signature sheet to confirm they have read and understood the policy	achievable	30/10/2020	Local management team

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.

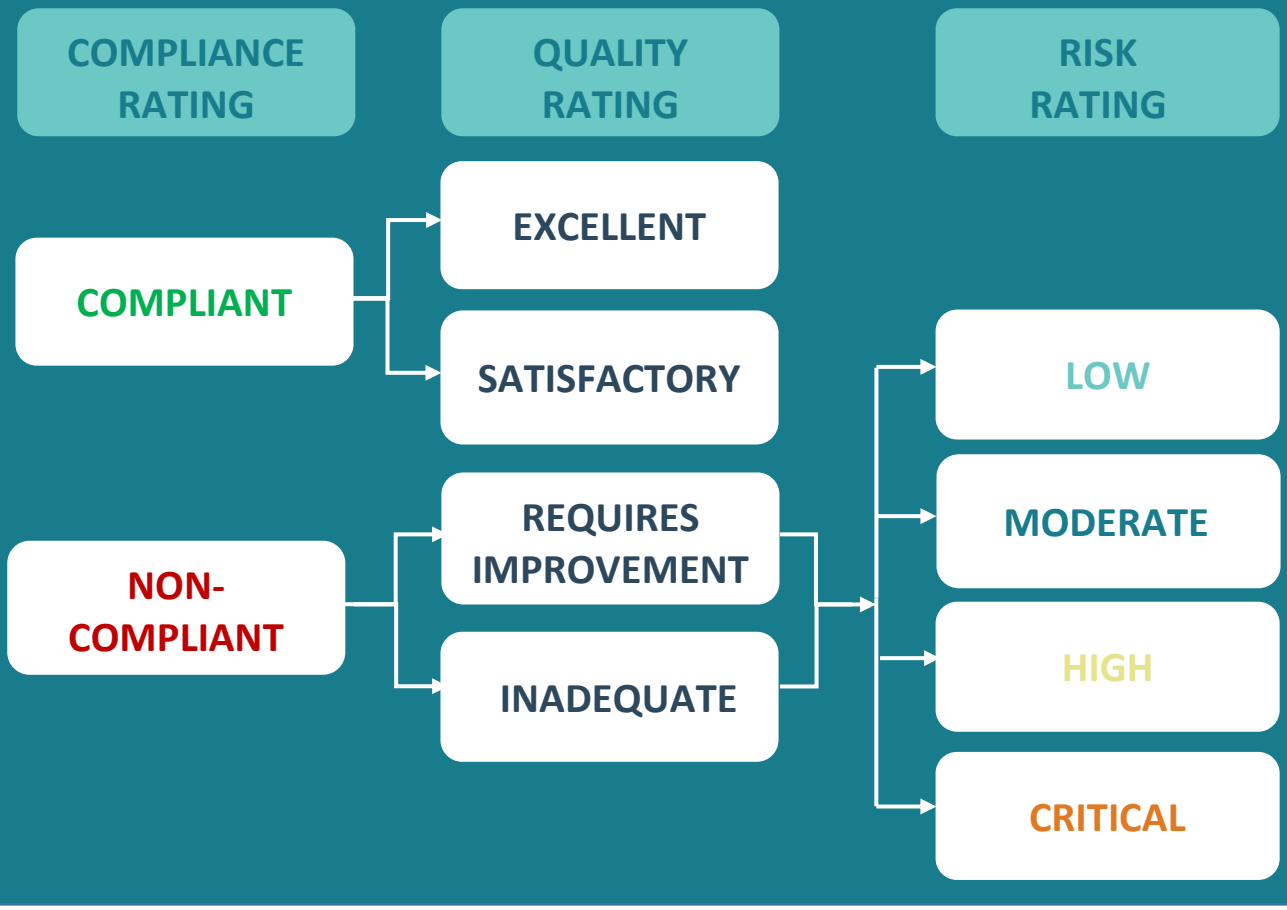
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly,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