St Patrick's Mental Health Services Overview

2019 Approved Centre Inspection Report (Mental Health Act 2001)

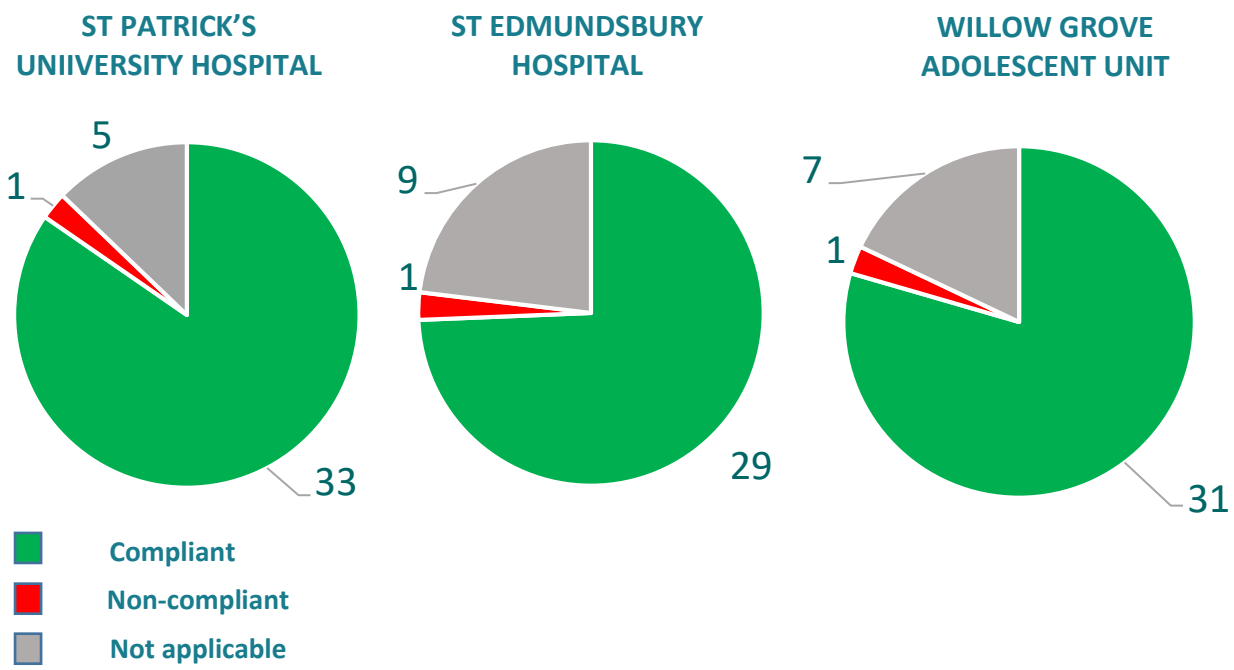
St Patrick's University Hospital
St Edmundsbury Hospital
Willow Grove Adolescent Unit, St Patrick's University Hospital

Inspection Dates:
11 – 14 June 2019

Date of Publication:
Thursday 12 March 2020

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

2019 COMPLIANCE RATINGS



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1.0 Inspector of Mental Health Services – Review of Findings

St Patrick's Mental Health Services, which incorporates three approved centres, had consistently maintained a high level of compliance ratings and findings of excellent compliance in many areas since 2007. In 2019, in view of this achievement and in line with risk-based regulation, the annual inspection was an announced inspection, and incorporated self-assessment in all regulations, rules and codes of practice. During the annual inspection, the inspectors validated the approved centres' self-assessments and inspected regulations, rules and codes of practice, which had a direct impact on patient care and safety.

In the 2019 annual inspection, the approved centres in St Patrick's Mental Health Services have maintained their high level of compliance with regulations, rules and codes of practice with an increased number of compliances rated as excellent. There was one area of non-compliance in Willow Grove and St Edmondsbury, and both of these non-compliances was rated as low risk. The service identified these non-compliances and had put in place corrective and preventative action plans by the time of the inspection.

1.1 Description of St Patrick's Mental Health Services

St Patrick's Hospital was formed by Royal Charter in 1746. The charter outlines the governance of the hospital through a board of governors consisting of both ex officio and appointed members. The governors have overall responsibility for internal control procedures and for reviewing their effectiveness. The running of the mental health service was carried out by a senior management team. St Patrick's Mental Health Services was an independent service and run on a not-for-profit basis.

St Patrick's Mental Health Service provide the following programmes:

Programmes
Anxiety Disorders Programme
Bipolar Education Programme
Depression Recovery Programme
Eating Disorders Programme
Addiction and Dual Diagnosis
Psychosis Recovery Programme
Young Adult Service
Older Adult Service
Adolescent Mental Health Service

On-line cognitive behavioural therapy (CBT) had been made available with the supervision of six psychotherapists. Face-to-face therapy was also available within this CBT service.

Twenty-five-day service programmes were provided and ran on a 10-week basis. There were seven outpatient Dean Clinics in the community, including Dublin, Galway and Cork. There have been 15,000 attendees to the Dean Clinics since their inception. Pre-assessment of need was obtained by phone. A nurse coordinator managed each clinic, and provided triage, enabling rapid access in urgent situations. A Team Liaison nurse provided linkage between in-patient and outpatient services.

Provision of psychoeducation, mental health awareness and relevant information was extensive, not only for service users attending the service, but also to the wider public, using various media options and campaigns. St Patrick's Mental Health service runs public awareness and education campaigns such as the anti-stigma *Walk in My Shoes* campaign. It also provided a free mental health information centre, based in St Patrick's University Hospital. The centre was run by hospital staff, with the assistance of a team of volunteers. The centre was open to current service users, family members, supporters and the general public. It provided guidance and help in accessing relevant mental health information and services, as well as information on support groups and service user rights and entitlements.

There were three approved centres in St Patrick's Mental Health services: St Patrick's Hospital, St Edmundsbury Hospital and Willow Grove Adolescent Unit. The in-patient services ran at approximately 90% bed occupancy.

The statutory annual inspection reports of each of these approved centres are provided within this report.

1.2 Description of approved centres

St Patrick's Hospital was an independent hospital and located in central Dublin. The original hospital structure was an 18th century listed building and was well maintained and decorated throughout. A variety of extensions had been developed over the years. It was registered for up to 241 residents. There were eight wards in St Patrick's Hospital: Dean Swift, including Special Care Unit (acute admissions); Stella, Grattan, Delaney, and Kilroot (general admissions); Vanessa (care of the elderly); Clara (eating disorders); and Temple (addictions service). Residents were under the care of 13 consultant teams.

St Edmundsbury was a refurbished 19th century Georgian house which included sitting rooms, recreational rooms, therapy rooms and kitchen-dining room facilities, as well as modern purpose-built resident accommodation. It had 52 beds, which were almost exclusively in single en suite rooms, with a small number of twin rooms. The approved centre provided treatment for voluntary residents only. Therapeutic services and programmes were provided either on-site or in St. Patrick's University Hospital. The approved centre provided transport between St. Edmundsbury and St. Patrick's Hospitals to enable residents to attend therapeutic and recreational programmes in both locations.

Willow Grove Adolescent Unit was a dedicated, stand-alone unit located within the grounds of St. Patrick's Hospital. It provided treatment to young people aged from 12 to 17 from all over Ireland. Willow Grove

accommodated up to 14 young people and plans were in development to build a further unit, attached to the existing unit, which would bring accommodation up to 27 beds when completed. All admissions to Willow Grove were planned, and an emergency service was not provided. Willow Grove offered a transgender service for young people, and dexa-scanning for young people with eating disorders. YAP, the youth advocacy service, provided an advocacy service for young people in residence in Willow Grove.

1.3 Governance

There was a Clinical Governance Committee which met weekly. Members of the Clinical Governance Committee included the Director of Services (Chairperson), the Clinical Director, the Director of Nursing, the Programme Manager for Clinical Governance, the Mental Health Act Administrator, the Head of the Social Work Department, the Nurse Practice Development Coordinator, and the Chief Pharmacist. The introduction of the eSwift on-line records had greatly assisted in managing information and generating reports.

St Patrick's Mental Health Services showed commitment in achieving compliance with regulatory standards, which they used to improve the quality of their service. It was evident that there was a drive to achieve a quality rating of excellent for each compliance. All staff were familiar with regulations, rules and codes of practice. Regulation was used to improve the quality of services provided, and to improve engagement with service users. Each approved centre had one area of non-compliance on this inspection. Each of the non-compliances had been identified by the service and had been corrected prior to the inspection and self-assessment. Actions to prevent re-occurrence were in place at the time of inspection.

Overall, there was strong evidence of a commitment from all staff to quality improvement. This was well-led at senior management level, and formed the culture of the organisation.

There was a large suite of audits covering clinical care and interventions, safety effectiveness and environment. A dedicated audit facilitator managed this through an annual schedule of audits. All clinical and non-clinical teams were involved in audits, which were submitted to the quality sub-committee of the Board. Outcome reports were generated, presented to staff, and used to improve clinical care.

A risk register was maintained and reviewed quarterly by the Board. Each director of a service or programme managed and had responsibility for risk in their department. Clinical risks were monitored and reviewed through the Clinical Governance Committee. Incidents were reported and documented, and learning from incidents formed part of risk management. For serious incidents, root cause analyses were undertaken.
Complaints about the services were dealt with by the complaints office and were submitted to the Clinical Governance Committee. Appeals of the complaints process or findings were referred to an external independent review.

There was a Service User and Supporter Council (SUAS), and a Service User Advisory Council (SUAN), within the service. The SUAS Council was a group of current and previous service users who represented the views of service users and their carers in relation to the treatment and care provided by the hospitals. The councils worked with management, the Board, clinicians, and services to ensure that this feedback was acted upon.

SUAN offered service users advice and input into the implementation of the service's strategic plan. Every project planned by the service was submitted to the service user advisory committee. An example of this was the plans for the Campus Transformation Project. There was a service user on all interview panels for staff. Service user satisfaction surveys were completed at the time of discharge and form part of improving services.

All staff were up-to-date with mandatory training. Other training was encouraged and funded, if appropriate to the needs of the service, including post-graduate training. There was a culture of research and of using best practice and evidence-based interventions. This was managed through a research department which had led to publication in peer-reviewed journals.

Recruitment of staff in all disciplines, apart from consultant psychiatrists, remained a difficulty, in common with other independent and public mental health services. Attrition of staff annually was approximately 5%. There was an active human resources plan with ongoing recruitment campaigns.

Plans for developing the service further were ongoing. Thirteen extra beds were planned for Willow Grove Adolescent service. This provision was included in an overall campus transformation project. This was to include public spaces such as galleries as well as locations for clinical services. The day service programme continued to be expanded, with an increased number of programmes and the recruitment of clinical staff.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Provision of further Speech and Language support through the contracting of a Clinical Specialist.

2. A modified form of the Family Connections™ programme had been developed by the social work department to support families caring for those formally diagnosed with a Borderline Personality Disorder or Emotionally Unstable Personality Disorder.

3. A number of resources had been produced to equip and support staff in caring for people who experience Intimate Partner Violence and Abuse.

4. The Service User Advisory Network was established to broaden the service user engagement structures within St Patricks Mental Health Services.

5. There was additional input from the physiotherapy department to promote service user physical activity.

6. There was a physical monitoring programme to improve service users' physical health. Each service user was offered extensive monitoring of their physical health when they presented to the service. There was a separate dedicated team of GPs, GP nurses and phlebotomy to provide this programme

7. There was an excellent pharmacy service in St Patrick's Mental Health Service, which consisted of an active and well-staffed pharmacy department of 7.2 whole-time equivalents. Pharmacists conducted regular audits, trained medical and nursing prescribers and provided information to service users. They were an integral part of the clinical multi-disciplinary team and each ward had an assigned pharmacist. They also provided input to each treatment programme. Each resident had a medication assessment by a pharmacist on admission.

8. There was a strong focus on multi-disciplinary (MDT) team working, which was evident in the care-planning process. MDT members provided a range of evidence based therapeutic programmes which included the day hospital programme. They were also involved in clinical audits, training and education and research.

In Willow Grove Adolescent Unit the following initiatives were noted:

1. An advocacy service for young people had been set up in Willow Grove in conjunction with Youth Advocacy Programmes (YAP) Ireland.

2. The Summer Therapeutic programme had been further developed to meet the needs of young people during the school holiday period.

3. A Parent Support group had been developed as a six-week programme to prioritise support and information to parents.

3.0 Compliance

3.1 Non-compliant areas on this inspection

Non-compliant (X) areas on the inspection of each approved centre were detailed below. Also shown was whether the service was compliant (✓) or non-compliant (X) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant.

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

St. Edmundsbury Hospital

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✓		X	Low

Willow Grove Adolescent Unit, St Patrick's University Hospital

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 28	✓		✓		X	Low

Each of these areas of non-compliance had been identified prior to the inspection and escalated to the Clinical Governance Committee. The service had put in place corrective and preventative action plans by the time of the inspection, which had addressed each non-compliance.

4.0 Feedback Meeting

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

- Registered Proprietor
- Acting Clinical Director
- Director of Nursing
- Director of Services
- Principal Psychologist
- Occupational Therapy Manager
- Principal Social Worker
- Consultant Psychiatrist x 2
- Clinical Nurse Manager 3
- Clinical Risk Manager
- Mental Health Act Administrator

The inspection team outlined the initial findings of the inspection process relating to the three approved centres and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

5.0 Conclusion

St Patrick's Mental Health Service was a well-led organisation with robust governance structures, which focused on quality improvement. This was evidenced by the high levels of compliance with regulations, rules and codes of practice in each of the approved centres, and also by the quality initiatives developed by the service. There was a strong emphasis on person-centred care, involving service users at all levels of management and in an advisory capacity. St Patrick's Mental Health Services engaged with the wider community through providing mental health information, stigma reduction, conducting surveys, and mental health promotion. Day hospital and outpatient services were also provided, and the expansion of these services, along with the adolescent mental health in-patient unit and service, was ongoing.

Staff were well trained and engaged with providing a quality service. The recruitment of staff remained a challenge for the service despite active recruitment programmes.

St. Patrick's University Hospital

ID Number: AC0005

2019 Approved Centre Inspection Report (Mental Health Act 2001)

St Patrick's University Hospital
James's Street
Dublin 8

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
n/a

Inspection Team:
Dr Susan Finnerty, MCRN009711, Lead Inspector
Noeleen Byrne
Siobhán Dinan
Raj Ramasawmy

Inspection Date:
11 – 14 June 2019

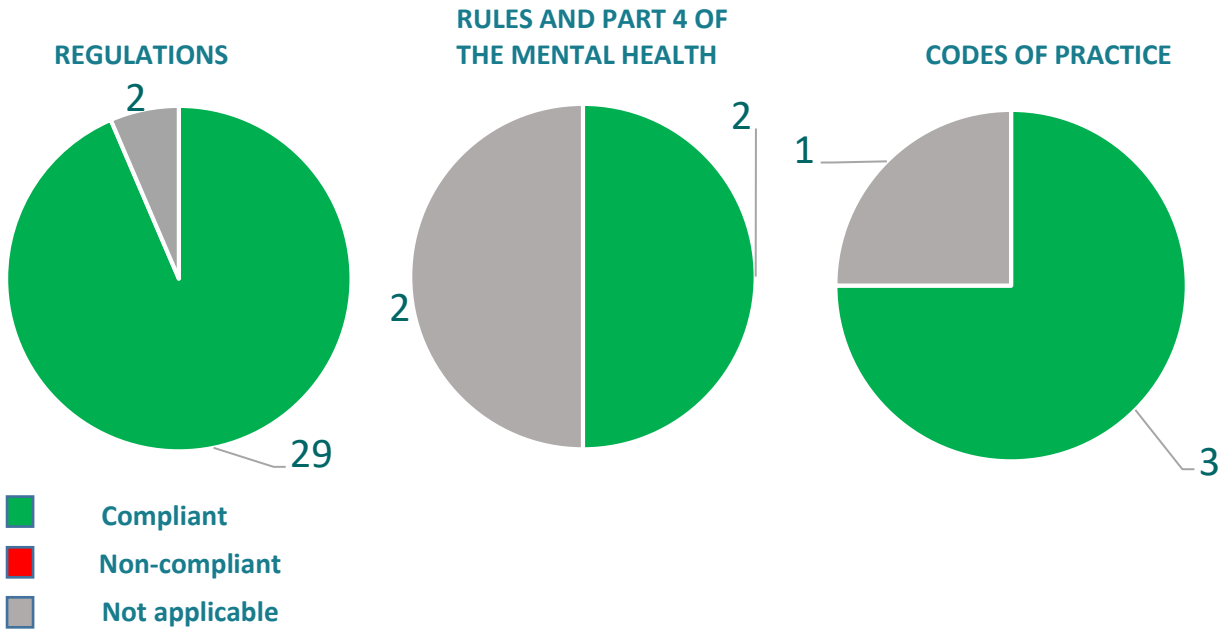
Inspection Type:
Announced Annual Inspection

Previous Inspection Date:
1 – 4 May 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
<<** – ** Month 2019>>

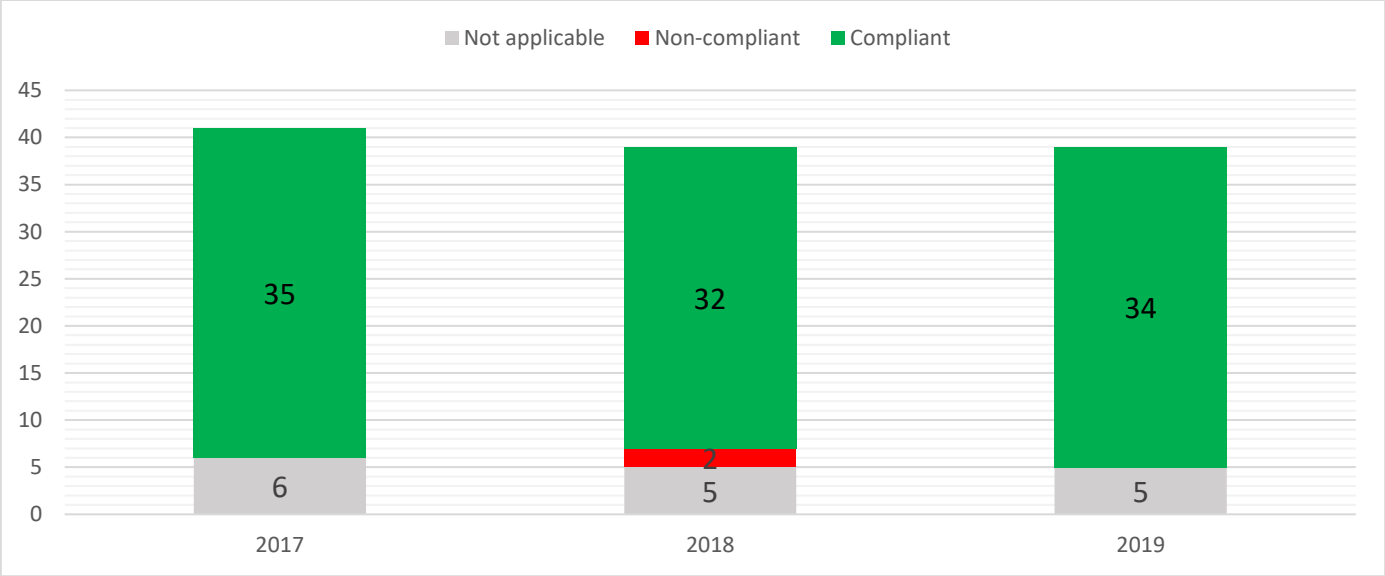
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

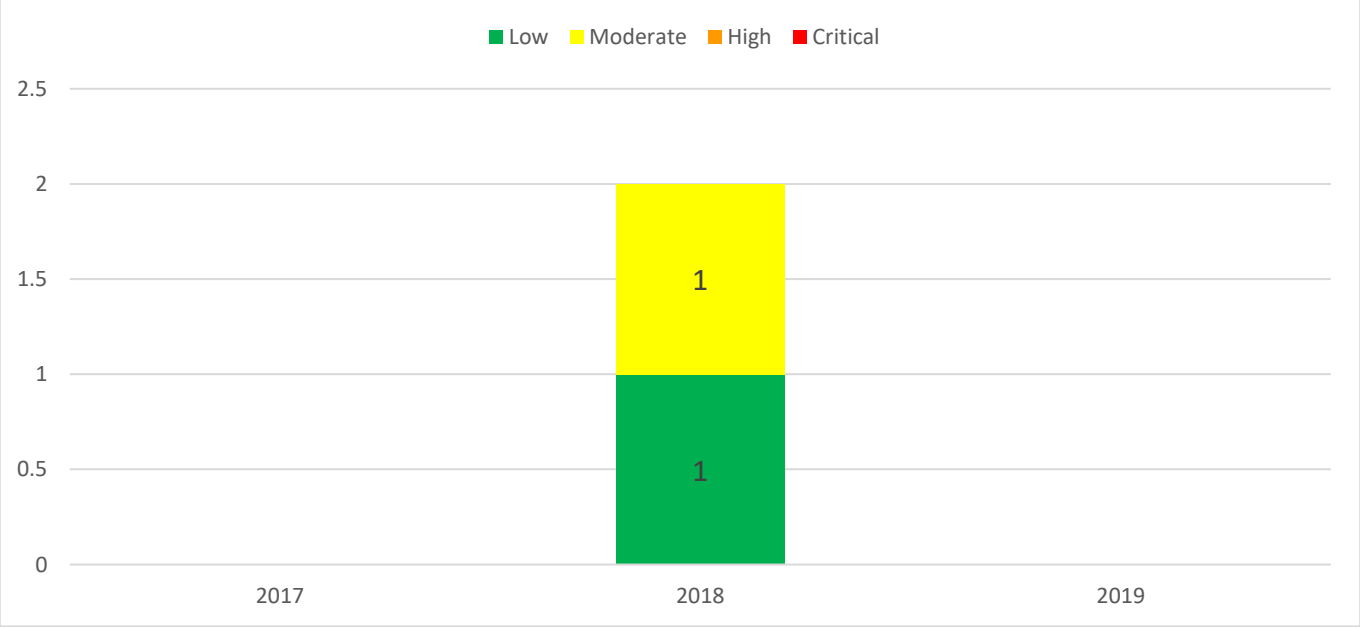
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



St Patrick's University Hospital had no areas of non-compliance in 2017 and 2019, therefore, no associated risk ratings for that year.

1.0 Overview of the Approved Centre

1.1 Description of approved centre

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service. It was located in central Dublin. The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The approved centre was registered for up to 241 residents.

The approved centre comprised eight wards: Dean Swift, including Special Care Unit (acute admissions); Stella, Grattan, Delaney, and Kilroot (general admissions); Vanessa (care of the elderly); Clara (eating disorders); and Temple (addictions service). The approved centre did not admit children.

The approved centre was well maintained and decorated throughout. From the reception area in the hospital to all the wards, the décor and furnishings made for a respectful and relaxed environment to service-users. There was an exhibition space available to residents, which provided a new artist's exhibition several times per year. A wide range of therapeutic services were offered. Residents had access to a large garden and therapy garden within the approved centre grounds.

During the course of the inspection, the approved centre accommodated 232 residents. There were six detained patients within the approved centre at the time of inspection. Residents were under the care of 13 consultant teams.

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

Resident Profile	
Number of registered beds	***241***
Total number of residents	**232**
Number of detained patients	6
Number of wards of court	0
Number of children	N/A
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

1.2 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.

2.0 Compliance

2.1 Non-compliant areas on this inspection

The approved centre was compliant with all Regulations, Rules and Codes of Practice.

2.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property & Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 14: Care of the Dying
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 22: Premises
Regulation 23: Ordering, Prescribing, Storing, & Administration of Medicines
Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

2.3 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.
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 Restrain	As the approved centre did not use mechanical means of bodily restraint, this rule 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.

3.0 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.

A total of eight residents met with the inspection team. All residents were invited to complete a questionnaire about their experience in the approved centre. In total, 15 questionnaires were returned. Residents stated that the staff were helpful and supportive and they felt safe in the approved centre. Residents stated that they were happy with the wide range of therapeutic programmes and recreational activities available to them and that they were involved in their individual care plan. Residents also liked the food and expressed having a choice of food to choose from. They felt that their privacy was respected and any concerns or complaints were addressed.

4.0 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 March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs, were used by staff. The preferred identifiers used for each resident were detailed within the residents' individual clinical files. Identifiers were person-specific, utilising photo identification, the date of birth, address of residents, and were appropriate to the residents' communication abilities. Two appropriate resident identifiers were used before the administration of medications, any medical investigations, or the provision of additional health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Alerts and appropriate identifiers were used to assist staff in telling the difference between 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 **Excellent**

(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 February 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 completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Menus in the approved centre were approved by a dietitian so as to ensure nutritional adequacy, in accordance with residents' needs, including the provision of daily hot meals. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid, and were offered at least two choices for meals. Hot and cold drinks were offered to residents at and between mealtimes, at regular scheduled intervals. A source of safe, fresh drinking water was available to the residents at all time, in easily accessible locations within the approved centre.

The St. Andrews Nutritional Screening Tool was used to assess nutritional and dietary needs during admission which were addressed in residents' individual care plans, and regularly reviewed by a dietitian, who advised the resident's multi-disciplinary team. Where deemed necessary and appropriate, weight charts were implemented, monitored, and acted upon. Residents, their representatives, family, and next of kin were educated about residents' diets, as required, specifically in relation to any contraindications with medication. Where appropriate, intake and output charts were maintained for residents.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a number of written policies in relation to food safety, all of which had been reviewed within the appropriate time frame. The policies included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Hygiene in the approved centre was maintained to support food safety requirements. The approved centre had suitable and sufficient catering equipment, along with proper facilities for the refrigeration, storage, preparation, cooking, and serving of meals. Appropriate hand-washing areas were provided for catering services, and protective equipment, including Personal Protective Equipment was used by those involved in the catering process. Catering areas and associated catering and food safety equipment were appropriately cleaned, and food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Residents of the approved centre were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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 resident was reported to have been prescribed wearing nightclothes during the day since the last inspection. A record of this was maintained and monitored on an ongoing basis.

Evidence of Implementation: Residents were supported to keep and use their own personal clothing that was clean and appropriate to their individual needs, and each resident had an adequate supply of individualised clothing. A stock of emergency personal clothing that was appropriate and took account of individual preferences, dignity, bodily integrity, and religious and cultural practices was available to the residents. Residents changed out of night clothes during day time hours unless specified otherwise in the resident's individual care plan. In addition, residents 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 **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had four written operational policies in relation to residents' personal property and possessions. The service user property policy was last reviewed in September 2018. The policies combined 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 were able to articulate that they had read and understood the policy.

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

Evidence of Implementation: Residents' personal property and possessions were safeguarded once the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of residents' monies, personal property, valuables, and possessions, as necessary. Individualised password-protected safes were located by each bedside throughout the service. Each ward had a locked store room to securely safeguard other, larger property. Residents were entitled to bring personal possessions with them to the approved centre, and items considered to be dangerous by the registered psychiatric nurse were removed for safekeeping, along with an explanation, until the resident's discharge.

Upon admission, the approved centre compiled a detailed property checklist for each resident of their personal property and possessions, which was updated on an ongoing basis. The property checklist was kept separately to the residents' individual care plans, and was also available to the resident. Residents' access to, and use of, monies was overseen by two members of staff, along with the residents or their representative. Where money belonging to a resident was handled by a member of staff, signed records of the staff issuing the money was retained, and, where possible, counter-signed by the resident or their representative. Residents were supported to manage their own property, unless risk assessed otherwise, as indicated in their ICP.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had six written policies in relation to the provision of recreational activities. The policy relating directly to recreational activities was last reviewed in May 2019. The policies combined 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 had signed the signature log to indicate that they had read and understood 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 a range of activities to facilitate recreational activities appropriate to the resident group profile, including age and ability. Activities included: TV, books, daily newspapers, walks, movies, pilates and board games. Daily activity sheets, both on weekdays and weekends, were delivered to each ward, and distributed to communal areas around the hospital. Information was provided to residents in an accessible format, appropriate to the residents' individual needs; the sheets were printed in large format, and staff were available to explain the timetable. Residents were invited to complete a twice-yearly survey to aid in the development of recreational activities programmes.

The recreational activities provided by the approved centre were appropriately resourced, with opportunities provided for both indoor and outdoor activity. The approved centre hosted an indoor gym with comprehensive equipment, a gym instructor, and gym facilitators, as well as outdoor exercise equipment. Communal areas were provided that were suitable for recreational activities. Documented records of residents' attendance at recreational activities were retained in group records.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in September 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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, and were supported to attended local religious services, where deemed appropriate following a risk assessment. Care and services that were provided within the approved centre were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment, were clearly documented. A formal assessment of each service user's belief systems during the initial nursing admission assessment. Residents were facilitated to observe or abstain from religious practice, in accordance with their wishes and values.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to visits. The policy concerning service user visitor control was last reviewed in May 2018. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: At the time of the inspection, there were no restrictions on residents' rights to receive visitors. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times to the approved centre were appropriate and reasonable, and were clearly and publicly displayed. A separate visitors' 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, including child visitors, during visits. The centre provided a child-friendly visiting room, which was accessible to all children visiting a resident once they were accompanied by a responsible adult. Notice of the requirement of children to be accompanied was communicated publicly to all relevant individuals.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to resident communications. The policies had all been reviewed within an appropriate time frame. The policies and procedures included all of the requirements of the *Judgement Support Framework.*

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

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 of the approved centre had access to mail, fax, e-mail, Internet, and telephone communication, unless otherwise risk-assessed with due regard to residents' well-being, safety, and health. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication, and documented in their individual care plans. A senior member of staff could examine incoming and outgoing resident communication only if there was reasonable cause to believe that the communication could result in harm to the resident or others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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 and procedures in relation to the implementation of resident searches, which was last reviewed in March 2017. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: Prior to the search of a resident, their property or environment, a risk assessment appropriate to the type of search was undertaken. Resident consent was sought prior to any and all searches. The request for consent, and the received consent, were documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. Details of, and the reasons for, any non-consensual searches were documented in the relevant residents' files. The resident search policy and procedures were communicated clearly to all residents. In

four instances since the approved centre's last inspection, consent had not been received prior to searches being implemented:
Residents were informed by those implementing the search of what was happening and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches in the approved centre were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search were of the same gender as the resident undergoing a search. A written record of every search of a resident, and of every environmental or property search, was maintained. In the case that illicit substances were found as a result of search, policy requirements were implemented. Searches of residents, their property or environment were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

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 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 number of written operational policies and protocols in relation to the care of the dying. The policy was last reviewed in August 2018. The policies and protocols combined included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: No end of life care had been provided by the approved centre since the last inspection. Systems analysis had been undertaken following a sudden or unexpected death.

Evidence of Implementation: Since the last inspection, three inpatient deaths had occurred. There was one case of a sudden or unexpected death onsite. The sudden death was managed in accordance with legal requirements, whereby the Dublin City Coroner and An Gardaí were notified immediately. The resident's sudden death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, in such a way that accommodated the resident's representatives, family, next of kin, and friends. In addition, support was given to other residents and staff following the resident's death. The Mental Health Commission was notified of all three resident deaths as soon as was practicable, and, in any event, no later than 48 hours after the death had occurred.

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

COMPLIANT

Quality Rating **Excellent**

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 number of written policies in place in relation to the development, use, and review of individual care plans (ICPs). The policy relating to the multi-disciplinary team (MDT) patient care plan and key working system was last reviewed in May 2019. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents' ICPs each comprised a composite set of documents, stored on an electronic health record system, which included allocated space for goals, treatment, care, and the resources required, and included space for reviews. Each ICP was stored within each resident's clinical file, was identifiable and uninterrupted, and was not amalgamated with progress notes. ICPs identified residents' assessed needs and documented appropriate goals for the residents, as well as the resources, care, and treatment required to meet the identified goals.

Ten clinical files were reviewed on inspection. In each file reviewed, the resident was initially assessed at admission, and an ICP was completed by the admitting clinician to address residents' immediate needs. An ICP was developed by the MDT following a comprehensive assessment of each resident, no later than seven days after admission. Comprehensive, and where possible, evidence-based, assessments were conducted, including: a medical, psychosocial, and psychiatric history; a history of present and past medications used; and a current physical health assessment. In addition, a review of social, interpersonal and physical environment-related issues, including resilience and strengths; and a review of residents' communication abilities took place.

ICPs were discussed, agreed where practicable, and drawn up with the participation of each resident, along with their representatives, family, and next of kin, as applicable. Residents' key workers were identified within the ICPs, which also included individual risk management and preliminary discharge plans. Residents had access to their ICPs, and were kept informed of any changes being made. Residents

were offered a copy of their ICPs, along with any reviews, and this was documented. When a resident refused to accept a copy, this was recorded, including the reason, if given.

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 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

(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 number of written policies in relation to the provision of therapeutic services and programmes, all of which had been reviewed within an appropriate time frame. The policies combined included all of the requirements of the *Judgement Support Framework.*

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to 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 appropriate and met the assessed needs of residents, as documented in their individual care plans. A list of the services and programmes provided was available. The therapeutic services and programmes provided by the approved centre were evidence-based, and were directed towards restoring and maintaining optimal levels of residents' physical and psychosocial functioning. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes.

Therapeutic programmes and services were provided in separate, dedicated rooms which contained facilities and space for individual and group therapies. These included a wide range of group rooms, a multi-purpose room on each ward for ward-based group activities, and separate offices for psychology, cognitive behavioural therapy, social work, and addiction counselling. A record was maintained within resident's individual care plans or clinical files of participation and engagement in and outcomes achieved in therapeutic services or programmes.

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 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: A transfer log was maintained, the clinical records of individual residents who had been transferred were reviewed, and communication with the receiving facility, both written and verbal, was documented. This communication included the reasons for transfer, the resident's care and treatment plan, and any accompaniment requirements. Documented assessment of the resident was completed prior to transfer, which included an individual risk assessment relating to the resident's needs. Consent from the resident pertaining to the transfer, or lack thereof with justification recorded, was available.

A checklist was completed by the approved centre to ensure that full and complete written information pertaining to the resident was transferred to the receiving facility once the transfer had been completed, with copies retained in the resident's clinical file in the approved centre. Relevant information, to be provided to a predetermined, named individual, accompanied the resident during their transfer to the receiving facility. As part of the transfer documentation, the following information was issued: a letter of referral, including a list of all current medications; a resident transfer form; and any medication required by the resident during the transfer process. If an emergency transfer was required for any reason, communications between the approved centre and receiving facility were documented, and followed up with a written referral.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in place in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in May 2019, and all other policies had been reviewed within an appropriate time frame. The policies and procedures included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre had an emergency trolley, and staff had access to an Automated External Defibrillator at all times. Twice-weekly checks were complete on the resuscitation trolley, and directly after use in the case of a medical emergency. Records were available of any medical emergency, and of the care provided to mitigate the emergency. A comprehensive systems' review and physical examination of each resident was carried out as part of the admission assessment. Residents received appropriate general health care interventions, in line with their individual care plans, and residents with any serious physical health needs were referred to the hospital's primary care service. The physical health needs of residents were reassessed at least every six months.

The clinical files of two individuals who had been in residence in the approved centre for longer than six months were examined during the course of the inspection. Both residents received a twice-yearly general health assessment which included: a physical examination; family history; Body Mass Index, weight, and waist circumference; blood pressure; smoking status; nutritional status; medication review; and a dental health check. For residents on antipsychotic medication, which both of the reviewed residents were on, an annual assessment of the following was also conducted: glucose regulation; blood lipids; prolactin levels; and Electro cardiogram.

Residents were assisted to access national screening programmes that were available, according to age and gender, including, but not limited to: breast check; cervical screening; retina check; and bowel

screening. Information of the different screening programmes available through the approved centre was provided to residents.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had six written policies and additional procedures in relation to the provision of information to residents. The policies had all been reviewed within an appropriate time frame. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre's information booklet that provided details on the care and services available. The booklet was available in the formats required to support residents' needs, with information being clearly and simply written, and residents were given access to interpretation and translation services when required. The booklet included details of: residents' rights; housekeeping arrangements; the complaints procedure; visiting times and arrangements; and relevant advocacy and voluntary agencies.

Residents were provided with details of their multi-disciplinary team, as well as written and verbal diagnosis unless the provision of such information could be deemed to be 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 the resident's clinical file. Information was provided to residents on the likely adverse effects of treatments, including risks and other potential side-effects. The information provided by or within the approved centre was evidence-based, and had been appropriately reviewed and approved prior to use.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had eighteen written policies relating to resident privacy, all of which had been reviewed within an appropriate time frame. The policies included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Staff in the approved centre treated residents with integrity, using each resident's preferred name, and communicating in a respectful manner, ensuring that no inappropriate comments or jokes were made at the expense of a resident. Staff dressed appropriately, in accordance with hospital policy and expectations, and residents were wearing clothing that respected their privacy and dignity. Residents were facilitated to make their own private phone calls using their own mobile phones or a portable ward phone that could be taken to their own room or another place of their choosing.

Staff sought residents' consent before entering residents bedrooms, announcing themselves and seeking permission. All bathrooms, showers, toilets, and single bedrooms had locks, which had an override function for emergencies unless there was an identifiable risk to a resident. Where residents shared a room, bed screening was put in place to ensure that their privacy was not compromised. Rooms were not overlooked by public areas, and all observation panels on the doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display residents' names or other identifiable information.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(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 written policies in relation to its premises. The policy relating to the departmental service plan was last reviewed in May 2019. Together, the policies included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit using the Manchester Ligature Audit Assessment Tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space in their bedrooms, as well as in break out areas, lounge areas, and multi-purpose rooms located on all wards in the approved centre. In addition, there were a number of areas located outside of the wards where a resident could choose to spend time alone, including a therapeutic garden. Sufficient space was provided for residents to move about. Appropriately-sized communal rooms were also provided. There was suitable and sufficient heating in the approved centre, and all rooms had windows and were well ventilated.

Private and communal areas were suitably sized and furnished so as to mitigate excessive noise. The lighting in communal rooms suited the needs of residents and staff, with lights being bright enough and appropriately positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support residents' orientation, and identified hazards, including ligature points, had been minimised to the lowest practicable level. Remote areas of the approved centre were monitored

both manually and using CCTV. The approved centre was kept in a good state of repair both inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, records of which were maintained. There was an individual cleaning schedule for each area within the approved centre. This ensured that the approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated, and monitored via a building management system, with pipe work and radiators guards. Heating could be safely controlled in the resident's own room, with radiator valves in situ. Where faults or problems were identified in relation to the premises, this was communicated through a maintenance reporting process.

The approved centre had a sufficient number of toilets and showers for the number of residents; toilets were accessible, clearly marked, and close to both day and dining areas. There was at least one assisted toilet per floor, and wheelchair accessible toilet facilities were available. Each ward had a designated sluice room, cleaning room, and a designated laundry room. The approved centre had dedicated examination and therapy rooms, and provided sufficiently-large sleeping areas or bedrooms, as applicable, for residents, and had appropriately sized lifts. Furnishings suitable to support resident independence and comfort were in place throughout the centre, and assisted devices and equipment were available where required to address residents' needs.

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

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

COMPLIANT

Quality Rating **Excellent**

(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 written policies in relation to the ordering, storing, prescribing, and administration of medication, all of which had been reviewed within an appropriate time frame. The policies included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Each resident had an MPAR, ten of which were reviewed during the inspection. Each MPAR demonstrated records of two resident identifiers, records of all medications administered, and details of dosage, frequency of medication, and route of administration. A record was kept of any medications refused by the resident, both in the MPAR and clinical file, and this was communicated to the relevant responsible staff. The Medical Council Registration Number of every registered medical practitioner (RMP) who had prescribed medication, and the Nursing and Midwifery Board of Ireland registration number of every nurse prescriber, as relevant, were included in each MPAR, accompanied by the signature of the relevant RMP or nurse prescriber.

Entries to each resident's MPAR were written electronically. Medication was reviewed and re-written at least every six months, or more frequently where required, and no prescription was altered where a change was required. Instead, a new prescription was written by the prescriber. All medicines, including scheduled controlled drugs, were administered by a registered nurse. When a resident's medication was withheld, the justification was noted in the MPAR and also recorded in the resident's clinical progress notes. Controlled drugs were checked by two staff members against the delivery form, and details were entered into the drug book, which directly corresponded to the controlled drug balance.

Residents, where they had successfully undergone a risk and competence assessment, were permitted to self-administer medications following risk assessment. However, where any change to the initial risk assessment was recorded, arrangements for self-administration were kept under review. Medication was

stored in the appropriate environment, in an area free from damp and mould, that was clean, free from litter, dust and pests, and free from spillage or breakage. Where medication required refrigeration, a log of the temperature of the refrigerated storage unit was taken daily. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose, quantity, and expiry date of all medications. Food and drink were not stored in areas used for the storage of medication.

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

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 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 written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The policies had all been reviewed within an appropriate time frame; the general health and safety policy was last reviewed in March 2019. The policies, procedures, and the safety statement included all of the requirements of the *Judgement Support Framework.*

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

Quality Rating **Excellent**

(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 73 written policies, and additional procedures, in relation to its staffing requirements, all of which been reviewed within an appropriate time frame. The policies and procedures addressed all of the requirements of the *Judgement Support Framework,* including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including Garda vetting requirements.
- The process for reassignment of staff in response to changing resident needs or staff shortages.

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skills mix of staff were reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: Staff were appropriately qualified to carry out their assigned responsibilities, and an appropriately qualified member of staff was on duty and in charge at all times. The approved centre employed staff whose numbers and skill mix were sufficient to meet residents' needs. This was demonstrated using an organisational chart which showed the leadership and management structure, as well as the existing lines of authority and accountability. A planned and actual staff rota was maintained, showing the staff on duty at any time. All staff were recruited and vetted in accordance with the approved centre's relevant policies and procedures, and information from referees was sought and documented during the recruitment process.

There was a written staffing plan in place which addressed the assessed needs of the resident group profile by considering: the approved centre's size and layout; the level of acuity of residents' psychiatric illnesses; the age profile; the average length of stay; the physical care needs and level of dependency of, and challenging behaviours exhibited by, the residents; and the number of beds available.

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. All staff were trained in: manual handling; dementia care; infection control and prevention; residents' rights; risk management; recovery-centred approaches to mental health care and treatment; incident reporting; and the protection of children and vulnerable adults.

All clinical and health care staff were also trained in the following:

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

All staff training was documented, and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre:

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

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (241)	241	100%	241	100%	241	100%	241	100%	241	100%
Consultant Psychiatrist (13)	13	100%	13	100%	13	100%	13	100%	13	100%
Medical (19)	19	100%	19	100%	19	100%	19	100%	19	100%
Occupational Therapist (10)	10	100%	10	100%	10	100%	10	100%	10	100%
Social Worker (13)	13	100%	13	100%	13	100%	13	100%	13	100%
Psychologist (18)	18	100%	18	100%	18	100%	18	100%	18	100%

Ward or Unit	Staff Grade	Day	Night
Clara	CNM2	1	1
	RPN	2	1
Ward or Unit	**Staff Grade**	**Day**	**Night**
Dean Swift	CNM2	1	1
	CNM1	1	0
	RPN	7	5
Ward or Unit	**Staff Grade**	**Day**	**Night**
Delaney	CNM1 or 2	1	0
	RPN	4	2
Ward or Unit	**Staff Grade**	**Day**	**Night**
Grattan	CNM1 or 2	1	0
	RPN	4	3
Ward or Unit	**Staff Grade**	**Day**	**Night**
Kilroot	CNM1 or 2	1	0
	RPN	4	2
Ward or Unit	**Staff Grade**	**Day**	**Night**
Stella	CNM1 or 2	1	0
	RPN	4	2
Ward or Unit	**Staff Grade**	**Day**	**Night**
Temple	CNM1 or 2	1	0
	RPN	4	2
Ward or Unit	**Staff Grade**	**Day**	**Night**
Vanessa	CNM1 or 2	1	0
	RPN	5	3

Other Clinical Staff Providing Cover in the Approved Centre	
Consultant Psychiatrists	13
Clinical Psychologists	18
Social Workers	13
Occupational Therapists	10
Pharmacists	6
Team Liaison Nurses	6

Cognitive Behavioural Therapists	6
Addiction Therapists	8

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN)

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

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of written policies and procedures in relation to the maintenance of records. The policy relating to data retention was last reviewed in May 2019. The policies and procedures addressed all of the requirement of the *Judgement Support Framework,* including the following.

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

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

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

Evidence of Implementation: All resident records were secure, up-to-date, in good order, and were constructed, maintained, used, and destroyed, as applicable, in accordance with national guidelines and legislative requirements. Documentation of food safety, health and safety, and fire inspections was maintained as required. All records were physically stored together in an electronic health record; in order to complete assessments or create records, every resident assessed or provided with care or services by the approved centre was required to have an individualised record. Residents' records were reflective of their current status, and of the care and treatment being provided to them. Individual clinical records were structured in a logical and facilitative way, and included identifiers that were unique to each resident.

Records were accessible to, and could be edited by, authorised staff only; staff had access to the relevant information and data needed to carry out their responsibilities. Residents' access to their records was managed in accordance with the Data Protection Acts. Entries in residents' records were factual, consistent, and accurate, and did not contain jargon, unapproved abbreviations, or meaningless phrases. Each entry included the date, the time, and was followed by a signature. Any errors made were scored out using a single line, and an audit trail of this was available electronically.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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 May 2017. The policy addressed all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre's operating policies and procedures were developed in concert with clinical and managerial staff. This was done in consultation with all relevant stakeholders, including service users, as appropriate, and incorporated relevant legislation, evidence-based best practice, and clinical guidelines. Operating policies and procedures were communicated to all relevant staff, after going through the appropriate approval process.

The operating policies and procedures, in line with relevant legislation, were reviewed on a cycle and at least once every three years. Obsolete versions of operating policies and procedures were retained, but removed from the possibility of access by staff.

The format of each operating policy and procedure was standardised, and included: the title; reference number; document owner; approvers; reviewers, where applicable; scope; implementation date; scheduled review date; and total number of pages in the policy and procedure. Where generic policies were used, the approved centre had a written statement adopting the policy and confirming that it would be reviewed at least every three years.

All regulations which required a policy had an up-to-date one in place.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedure in relation to the facilitation of Mental Health Tribunals, which was last reviewed in July 2018. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre provided a dedicated meeting room in order to facilitate Mental Health Tribunals, and had sufficient resources to support the Tribunals process. Staff attended Tribunals to provide assistance, as necessary, where a patient required assistance to attend or participate in the process.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented, and the findings acted upon. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented in order to ensure continuous improvement of the complaints management process.

Evidence of Implementation: The approved centre had a nominated person who was responsible for dealing with complaints, the management of which was dealt with using a consistent and standardised approach. Residents and their representatives were facilitated to make complaints using the methods detailed in the complaints policy and procedure. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate the participation of residents in the complaints process.

The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. Information about the complaints procedure was provided upon admission, or soon thereafter; the complaints procedure, and the contact details of the nominated person

were publicly displayed; and residents and their representatives were informed of the ways in which a complaint could be made. All complaints were handled promptly, appropriately, and sensitively. Where complaints could not be appropriately addressed by the nominated person, they were escalated in accordance with the approved centre's policy, and this was documented in the complaints log.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being made. Whether oral or written, all complaints were investigated promptly, and handled sensitively and appropriately. All staff were aware of the process in place for dealing with minor complaints, which were escalated to a line manager who would endeavour to address the complaint satisfactorily, and which would be documented. Where minor complaints could not be addressed locally, the nominated person would deal with the complaint. The complainant was informed promptly of the outcome of the complaint investigation, and details of the appeals process were made available to them.

All information obtained during the course of the management of a complaint, and the associated investigation process, was treated in a confidential manner, and met the requirements of the Data Protection Acts 1988 and 2003, as well as the Freedom of Information Act 1997 and 2003. Details of complaints, subsequent investigations, and their outcomes were fully recorded and kept separate from the resident's individual care plan. The complainant's opinions on an investigation's findings were documented.

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 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

(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 number of written policies in relation to risk management and incident management procedures, all of which had been reviewed within an appropriate time frame. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the risk management processes, as set out in the policies. All training was documented.

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

Evidence of Implementation: The person with responsibility for risk was known to all staff. In addition, responsibilities were allocated at management level and throughout the approved centre to ensure effective implementation. Clinical, health and safety, structural, and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register, as appropriate. All risks identified in the risk register were mitigated to reduce the risk of their occurrence.

Individual risk assessments were carried out prior to and during: episodes of restraint; specialised treatments; at admission, transfer and discharge; and in conjunction with medication requirements or administration. The multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management procedures. Residents and their representatives, as relevant, were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by members of the resident's MDT at their regular meeting, and a record of the review and recommended actions was maintained. The person with responsibility for risk management reviewed incident data for any trends or patterns emerging. The approved centre provided a twice-yearly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan in place, incorporating evacuation procedures, and specifying responses by the approved centre's staff in relation to possible emergencies.

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 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 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 a prominently displayed, up-to-date certificate of registration.

The approved centre was compliant with this regulation.

5.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually, and was dated February 2019. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of anaphylaxis and malignant hypothermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite with a private waiting room, and adequately-equipped treatment room, and an adequately-equipped recovery room. High-risk patients were treated in a rapid-intervention area. Regular maintenance of the ECT machines was undertaken, a record of which was kept, and there was confirmation of servicing of ECT machines. Materials and equipment used in the ECT suite, including emergency drugs, were in line with best international practice.

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hypothermia were prominently displayed in the ECT treatment and recovery rooms. At least two registered nurses, one of whom was a designated ECT nurse, were present in the ECT suite at all times during treatment.

The clinical files of two patients who were prescribed ECT were inspected. The files indicated that the patients had received appropriate information about the treatment, including details of likely adverse effects, and had also been informed of their rights to an advocate. The patients had the opportunity to raise questions at any time. The programmes of ECT were prescribed by the responsible consultant psychiatrist, and recorded in the patients' clinical files, which also contained a pre-anaesthetic assessment, and an anaesthetic risk assessment. The consultant psychiatrist, in consultation with the patients, regularly reviewed progress and the need for continuation of ECT.

A written record of the assessments of capacity to consent to ECT was detailed in each of the patients' clinical files. These indicated that both patients were unable to give informed consent to treatment. ECT

was administered in accordance with section 59(1)(b) of the Mental Health Act 2001. For each patient, a *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed, place in the clinical files, and a copy of was sent to the Mental Health Commission within five days.

The ECT records which had been completed following each treatment session was placed in the patients' clinical files, and the signature of the registered medical practitioners administering ECT for each patient was detailed. All pre- and post-ECT assessments were detailed and recorded in the clinical file. In both cases, the ECT register was completed upon conclusion of the ECT programmes, and a copy of the same was placed in each of the patients' clinical files, along with copies of all cognitive assessments.

The approved centre was compliant with this rule.

6.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

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

INSPECTION FINDINGS

The clinical files of three detained patients who had been in the approved centre for more than three months, and who had been in continuous receipt of medication, were examined. One of the three patients had consented to treatment, and there was a written record to this effect, which detailed the following:

- The name of the medications prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient which had taken place on the nature and purpose of the medication, the effects of the medications, including the risks and benefits, and any views expressed by the patient, and any supports provided to the patient in making the decision to consent.

Two of the patients were unable to consent, and this was documented. In both cases, a *Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* had

been appropriately completed. Each of the Form 17s included details of the discussions with the patients on the nature, purpose, and effects of the medications being used. Any views expressed by the patients were recorded. In each case, authorisation was provided by a second consultant psychiatrist, and in both cases, an assessment of the patient's ability to consent to treatment had been completed.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

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 physical restraint. The policy had been reviewed annually, was dated September 2018, and addressed the following:

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read, familiarised themselves with, and understood the policy.

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

Evidence of Implementation: The records of three episodes of physical restraint were inspected. These records indicated that the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the resident or others. In all cases, physical restraint was only used after all alternative interventions to manage the residents' unsafe behaviour had been considered. Physical restraint was initiated only after a risk assessment had been conducted, and cultural awareness and gender sensitivity were demonstrated when considering the use of, and when using, physical restraint.

In all three cases, physical restraint was initiated a registered nurse, in accordance with the policy. In two cases, a designated staff member was responsible for leading in the physical restraint of the residents, and for monitoring the head and airways; in the third case, a low-level management of actual or potential aggression technique was used, avoiding the need for the monitoring of the resident's airways. Two of the three episodes lasted for less than 30 minutes, while the order relating to the third episode was extended for a total of 49 minutes by the Registrar in attendance. The episodes were all recorded in the residents' clinical files, and the physical assessments were completed within three hours of the episode of physical restraint.

All three residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. One of the residents refused consent to inform their next of kin following the episode of restraint, while the other two residents' representatives were informed as soon as was practicable. A same sex staff member was present at all times during each of the episodes, and the residents were afforded the opportunity to discuss the episode with members of their multi-disciplinary teams (MDTs) as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the residents' clinical files no later than two working days following the episodes.

The approved centre was compliant with this code of practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS0

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated February 2019. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest, anaphylaxis, and malignant hypothermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The suite had a private waiting room and adequately-equipped treatment and recovery rooms. Material and equipment for ECT, including emergency drugs, were in line with best international practice. Up-to date protocols for the management of cardiac arrest, anaphylaxis, and hypothermia were prominently displayed in the approved centre. ECT machines were regularly maintained and serviced, and this was documented. A named consultant psychiatrist had responsibility for the management of ECT, and a named consultant anaesthesiologist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one patient who had commenced ECT as an involuntary patient and who was incapable of consenting to ECT, was examined. This patient became a voluntary patient during the programme of ECT. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the resident's clinical file. Sufficient information was provided to the resident by the consultant psychiatrist in order to enable the patient to make a decision on consent. Information on the likely adverse effects of ECT, including the risk of cognitive impairment, amnesia, and other potential side-effects, was provided.

The voluntary patient signed consent for the next episode of ECT, but overall consent for continuing ECT and anaesthesia was not signed, and there was therefore no written confirmation of capacity to consent, or that the resident had received information about ECT, or that they had the right to withdraw consent at any time.

A programme of ECT for the voluntary patient was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that had proved ineffective prior to the prescription of the treatment, the discussion with the voluntary patient, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an

anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine.

The ECT record which was completed after every treatment, and all pre- and post-ECT assessments, were placed in the resident's clinical file, along with the reasons for continuing or discontinuing ECT. The signature of the registered medical practitioners administering ECT were detailed.

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, the admission policy having been reviewed in February 2019, the transfer and discharge policies in May 2019. The policies combined included all of the policy-related criteria of the 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 clinical file of one resident was inspected in relation to the approved centre's admission process. An admission assessment was completed, confirming that the resident was admitted on the basis of a mental illness or disorder. The assessment included details of the resident's: presenting problem; psychiatric history; family history; medical history; current and historic medication; current mental state; a full physical examination; a risk assessment; and any other relevant information. A representative or family member of the resident was involved in the admission process, with the resident's consent. The resident was assigned a key worker on admission.

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

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed on inspection. The discharge had been co-ordinated by a key worker, and a discharge plan was in place as part of the individual care plan. The discharge plan included: the estimated date of discharge; documented communication with the relevant primary care team or general practitioner; a follow-up plan; and a reference to early warning signs of relapse and risks. A discharge meeting was attended by the resident, their key worker, relevant members of the multi-disciplinary team, and the resident's family, carer, or advocate, as appropriate.

A discharge assessment was conducted, which included: the resident's psychiatric and psychological needs; a current mental state examination; a comprehensive risk assessment and risk management plan; and informational needs. A preliminary discharge summary was sent to the resident's general practitioner or community mental healthcare team within three days, and a comprehensive discharge summary within 14 days. The discharge summary included details of: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; risk issues such as signs of relapse; and the names and contact details of key people to follow up with. A timely follow-up appointment was organised, and family members, carers or advocates were involved in the discharge process, where appropriate.

The approved centre was compliant with this code of practice.

St. Edmundsbury Hospital

ID Number: AC0057

2019 Approved Centre Inspection Report (Mental Health Act 2001)

St. Edmundsbury Hospital
Lucan
Co Dublin

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
25 May 2019

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
N/a

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

Inspection Date:
11 – 14 June 2019

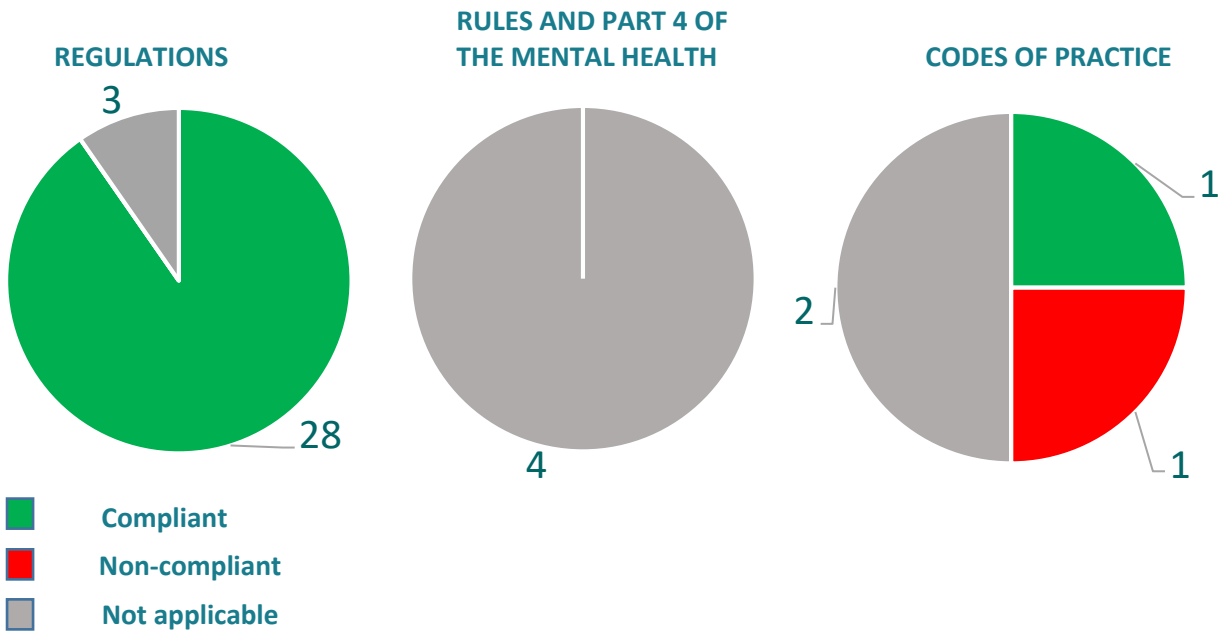
Inspection Type:
Announced Annual Inspection

Previous Inspection Date:
27 – 30 November 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
<<** – ** Month 2019>>

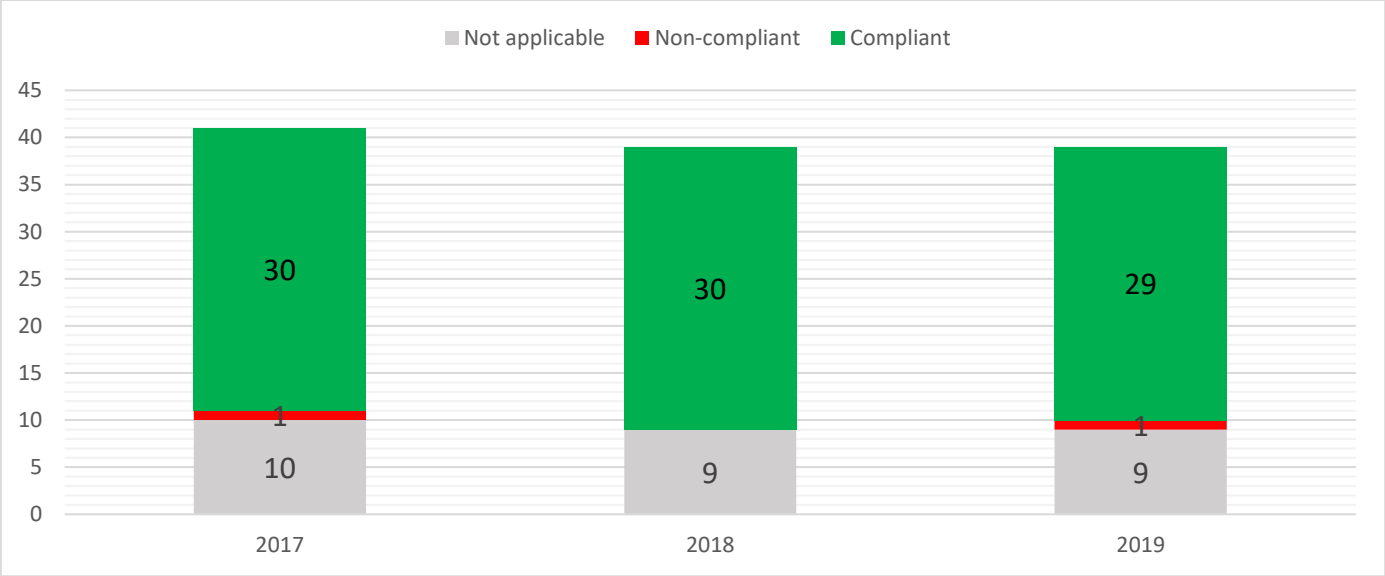
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

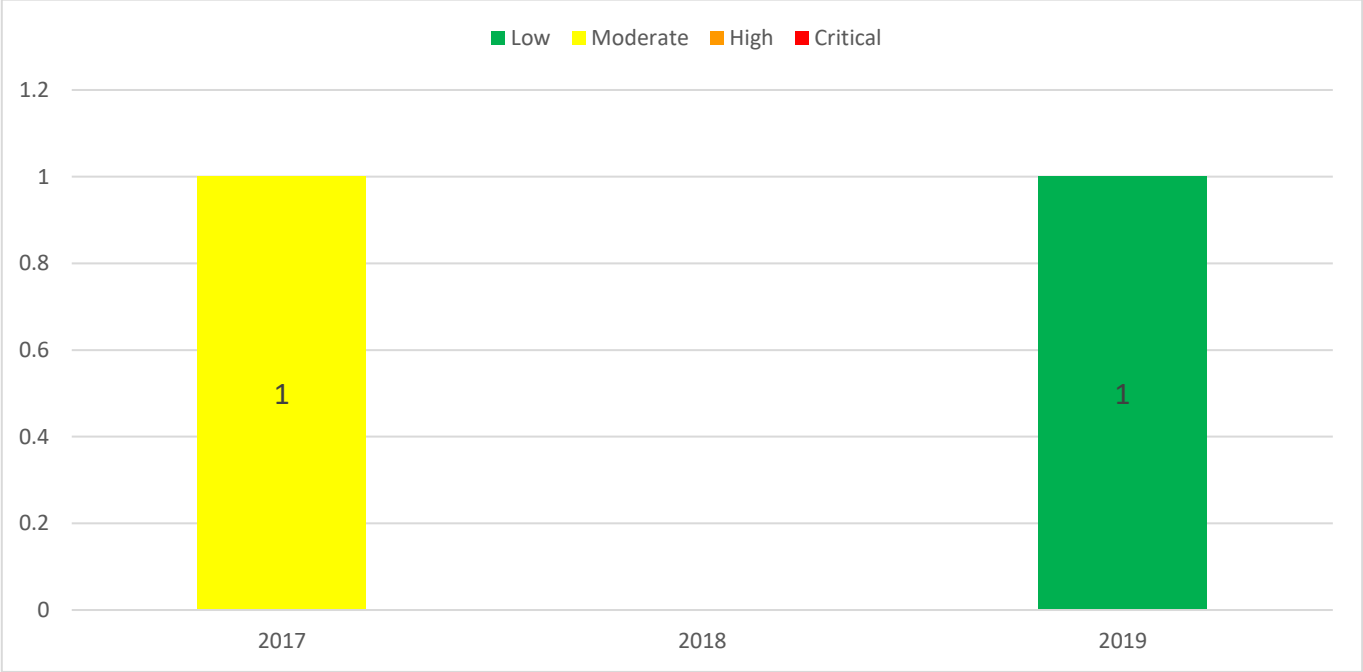
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



St. Edmundsbury Hospital had no areas of non-compliance in 2018 and no associated risk ratings

1.0 Overview of the Approved Centre

1.1 Description of approved centre

St. Edmundsbury Hospital in Lucan was part of the wider St. Patrick's Mental Health Services organisation, which was a registered charity. The management of the approved centre was integrated with the service's two other approved centres, with overall management undertaken by of a Board of Governors established by charter. The approved centre consisted of a refurbished 19th century Georgian house which included sitting rooms, recreational rooms, therapy rooms and kitchen-dining room facilities, as well as modern purpose-built resident accommodation.

The approved centre provided accommodation facilities for 52 beds, which was almost exclusively in single en suite rooms with a small number of twin rooms. Referrals to the approved centre came from general practitioners nationally. The approved centre provided treatment for voluntary residents only. Therapeutic services and programmes were provided either on-site or in St. Patrick's University Hospital. The approved centre provided transport between St. Edmundsbury and St. Patrick's Hospitals to enable residents to attend therapeutic and recreational programmes in both locations.

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

Resident Profile	
Number of registered beds	***52***
Total number of residents	**45**
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	0
Number of patients on Section 26 leave for more than 2 weeks	0

1.2 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.

2.0 Compliance

2.1 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 in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✓		✗	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.

2.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 22: Premises
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints Procedures

Regulation 32: Risk Management Procedures

2.3 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.

3.0 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.

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.

The inspection team spoke with seven residents and received 11 completed resident questionnaire leaflets, over the course of the inspection. Residents were very complimentary of the care and treatment that was provided to them and the residents made reference to the very good nursing, medical, and occupational therapy care provided. Residents were also enthusiastic about the information lectures provided on a daily basis, which they felt were very beneficial to their understanding and to their recovery journey.

A number of areas for improvement were stated by residents, these included:

- Some residents described not being invited to their multi-disciplinary team meeting although they completed a resident expectation form.
- The cancellation of some planned activities without any substitute being made available.
- The quality of food, especially at teatime being of an inadequate standard and lacking choice, with food served on cold plates and tea cold in teapot.
- The dining room was also described as busy and difficult to navigate through at mealtimes.
- Showers were also stated to be difficult to regulate in terms of temperature and duration of flow.
- Some residents also felt that there was an inadequate resource of nursing staff at times during the week.

Where any resident brought a matter to the attention of the inspectors during the inspection process, that query or concern was relayed on an anonymised basis to clinical/administrative staff, who undertook to follow it up.

4.0 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 March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: There were no residents in the approved centre with the same or similar name. A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The approved centre used address, photograph, and date of birth of each resident as identifiers. The identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

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 **Excellent**

(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 series of policies in relation to food and nutrition, which were last reviewed in April 2019. The nutritional care policy was last reviewed in April 2019. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre's menus were approved monthly by a dietitian to ensure nutritional adequacy in accordance with the residents' needs.

Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly, and fresh water was available at all times.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Their 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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies in relation to food safety. The food safety and quality policy was last reviewed in April 2019. The policies combined included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policies. All staff handling food had up-to-date training in food safety/hygiene commensurate with their role. Staff 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, and a temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

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

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. A record of residents wearing nightclothes during the day, as indicated by their individual care plan, was maintained and monitored.

Evidence of Implementation: No resident was prescribed to wear nightclothes during the day since the last inspection. Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents 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 **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had four written policies in relation to residents' personal property and possessions. The service-user property policy was last reviewed in September 2018. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Nine clinical files were reviewed in relation to residents' personal property and possessions. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre's policy.

Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions. All residents had their own personal safe by their bedside, with individualised password protected safes. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities was displayed on noticeboards and in communal areas around the approved centre.

Activities included internal gym, external exercise equipment, bingo, guided meditation, outdoor exercise, snooker, and film viewing. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre offered access to group rooms, garden space, multipurpose rooms, a family room, and a games room.

Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in group records.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to the facilitation of religious practice by residents. The service user religion and spiritual care policy was last reviewed in May 2019. The policies included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The admitting nurse carried out a formal assessment of each residents immediate belief systems during the initial Nursing Admission Assessment and this was documented. Residents' rights to practice religion were facilitated within the approved centre, and there was a multi-denominational oratory available to support residents' religious practices. Weekly Mass was held in the approved centre. Residents had access to multi-faith chaplains, if required. Residents had access to local religious services such as Mass in Lucan village, and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had four written policies and procedures in relation to visits. The service user visitor control policy was last reviewed in May 2018. The policies included the requirements of the *Judgement Support Framework*.

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

Monitoring: At the time of inspection there were no restrictions on residents' rights to receive visitors. Analysis was completed to identify opportunities to improve visiting processes. This was documented.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. It was possible for visits to take place in open visiting areas and in multipurpose rooms.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. Visitors with children had use of the child-friendly multipurpose room. This room had a snooker table, and a games area with resources available for children to play with.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had fifteen written operational documents and procedures in relation to resident communication. The Service User Access To Communication Facilities Policy was last reviewed in March 2017. The policies combined included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: At time of the inspection, there were no restrictions on residents' communications. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, email, internet, and telephone if they wished. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. The Clinical Director/senior staff member designated by the Clinical Director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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 four written operational policies and procedures in relation to the implementation of resident searches. The service user searches policy was last reviewed in March 2017. The policies addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had been completed to identify opportunities for improvement of search processes.

Evidence of Implementation: The resident search policies and procedures were communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Environmental searches were not routinely carried out. The clinical file of two residents who were searched were inspected. Each resident's consent was sought and documented, prior to the search taking place.

Risk had been assessed prior to the search of each resident, their property, or the environment, appropriate to the type of search being undertaken. Each resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

The search was implemented with due regard to the resident's dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

A written record of every search of a resident, and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

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

Regulation 14: Care of the Dying

COMPLIANT

(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 seven written operational policies and protocols in relation to care of the dying. The care of the dying service user and their families' policy was last reviewed in August 2018. The policies combined included all of the requirements of the Judgement Support Framework.

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

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Excellent**

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 series of written policies in relation to the development, use, and review of individual care plans (ICPs). The Assessment and Reassessment policy was last reviewed in April 2019. The policies included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Each resident had an ICP, ten of which were inspected. The ICP in the approved centre was part of the online electronic health records. The system was called eSwift electronic health record. A key worker was identified to ensure continuity in the implementation of a resident's ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Residents had been assessed at admission by the admitting clinician and an initial ICP was completed by the admitting clinician to address the immediate needs of the resident. All residents received an evidenced-based comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, and next of kin, as appropriate. Family were involved in residents' ICPs with residents' consent.

The ICPs identified residents' assessed needs, appropriate goals, the care and treatment required to meet the identified goals including the frequency and staff responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan. All ICPs inspected had a preliminary discharge plan documented.

The ICP was reviewed by the MDT in consultation with the resident regularly. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews.

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 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

(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 series of written policies in relation to the provision of therapeutic services and programmes. The Alcohol and Chemical Dependency Programme Service Plan Policy was last reviewed in October 2018. The policies combined included all of the requirements of the *Judgement Support Framewor*k.

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 therapeutic activities and programmes, as set out in the policies.

Monitoring: The range of services and programmes provided in the approved centre were 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: All therapeutic services and programmes provided by the approved centre were extensive, evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was displayed to residents on noticeboards throughout the approved centre. All therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Adequate resources and facilities were available. Therapeutic services and programmes were provided in separate dedicated rooms, and each ward had facilities to carry out group programmes or one to one sessions. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents' clinical files.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies and procedures in relation to the transfer of residents. The transfer of a service user to and from an approved centre was last reviewed in May 2019. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre, in a non-emergency situation was examined. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This communication included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and the resident's accompaniment requirements on transfer.

The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident's needs. Relevant documentation was issued as part of the transfer, with copies retained, including a letter of referral with a list of current medications and a resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident's clinical file.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(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 series of written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The physical examination and systems review policy was last reviewed in May 2019. The medical emergencies policy was last reviewed in February 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A systematic review had been undertaken to ensure that six-monthly general health assessments of residents where appropriate, had occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator. Emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with their individual care plans. Where indicated, registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, but not less than every six months. At the time of the inspection, no resident was an inpatient for more than six months.

In relation to residents on antipsychotic medication, there was no resident in the approved centre for twelve months, and the annual assessment had not taken place due to this reason. Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. The primary care unit was available in St. Patrick's Hospital and medical physicians were contracted to provide services to the approved centre. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes appropriate to age and gender.

Information was provided to all residents regarding the national screening programmes available. Multi-disciplinary teams supported service users to quit smoking through ongoing support and prescription of nicotine replacement therapy.

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 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written operational policies and procedures in relation to the provision of information to residents. The Service User Access to Communication Facilities was last reviewed in March 2017. The policies combined included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents were provided with a service-user booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident's diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to

the resident, including any possible side effects. Residents had access to interpretation and translation services as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a series of operational policies in relation to resident privacy, The Maintaining Service Users' Privacy when accessing SPMHS, was last reviewed in March 2017. The policies addressed all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The general behaviour of staff and the way in which staff interacted with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, and these locks had an override function. Rooms were not overlooked by public areas. Where residents shared a room, bed screening ensured that their privacy was not compromised.

Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls, and residents kept their own mobile phones to use as they wished – either in their bedroom or anywhere else on the ward.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(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 series of written policies in relation to its premises, the Departmental Service Plan policy was last reviewed in May 2019. The policies combined addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence Of Implementation: The approved centre was adequately lit, heated, and ventilated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. All resident bedrooms were appropriately sized to address the resident needs. There was sufficient space for residents to move about, including outdoor spaces. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised throughout the approved centre. The approved centre had minimised ligature points to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. 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. Backup power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. The approved centre had a designated therapy and examination room. The approved centre provided assisted devices and equipment to address resident needs, and there were appropriately sized lifts where applicable. Remote or isolated areas of the approved centre were monitored through CCTV and manual monitoring.

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 23: Ordering, Prescribing, Storing and Administration of Medicines

COMPLIANT

Quality Rating **Excellent**

(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 series of written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication; one of which was last reviewed in April 2018. The policies combined included the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Each resident had an MPAR, five of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's on-screen MPAR. A record was kept when medication was refused by the resident.

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

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Medication fridges were kept locked. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.

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

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

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 over twenty written documents, including policies, in relation to the health and safety of residents, staff, and visitors. The policies and associated documents combined addressed all the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

Quality Rating **Excellent**

(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 series of written policies and procedures in relation to the recruitment, selection and vetting of staff. All policies were in-date. The policies combined 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 relevant policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place, which identified the leadership and management structure, and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the approved centre's policies and procedures for recruitment, selection, and appointment. Staff had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

Opportunities were made available to staff by the approved centre for further education. The number and skill mix of staffing were sufficient to meet residents' needs. A written staffing plan was available within the approved centre. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff were trained in manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management, and treatment, incident reporting, and the protection of children and vulnerable adults.

All health care staff were trained in fire safety, Basic Life Support, management of violence and aggression, Children First, and the Mental Health Act 2001.

All staff training was documented and staff training logs were maintained.

The following is a table of staff mandatory training levels in the approved centre:

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (26)	26	100%	26	100%	26	100%	26	100%	26	100%
Consultant Psychiatrist (3)	3	100%	3	100%	3	100%	3	100%	3	100%
Medical (3)	3	100%	3	100%	3	100%	3	100%	3	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (3)	3	100%	3	100%	3	100%	3	100%	3	100%
Psychologist (4)	4	100%	4	100%	4	100%	4	100%	4	100%
Other	5	100%	5	100%	5	100%	5	100%	5	100%

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

Ward or Unit	Staff Grade	Day	Night
St. Edmundsbury	CNM1	1	0
	RPN	5	3
	Occupational Therapist	2	
	Social Worker	2	
	Psychologist	3	
	Consultant Psychiatrist	3	
	Medical	3	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN)

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 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies and procedures in relation to the maintenance of records, the data breach management policy was last reviewed in November 2017. The policies combined addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policies. 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 policies. All clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All residents' records were electronic, on-screen health records. Records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided. Residents' access to their records was managed in accordance to the Data Protection Acts.

Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation. Only authorised staff made entries in residents' records. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Electronic health records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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 two written policies in relation to the development and review of operating policies and procedures required by the regulations. The policy and procedures development and approval policy was last reviewed in May 2017. The policies combined included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff 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 policies.

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

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

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

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed and the details of the analysis were considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

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

All complaints were handled promptly, appropriately and sensitively. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre's policy. This was documented in the complaints log.

The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints, apart from minor complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process made available to them.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. The complainant's satisfaction or dissatisfaction with the investigation findings was documented.

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 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All training was documented. 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.

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

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and seclusion, electro-convulsive therapy, and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. Incidents were also reviewed by regular Clinical Governance and Occupational Risk and Safety Committee meetings.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. 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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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 in the approved centre.

The approved centre was compliant with this regulation.

5.0 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 2.3 Areas of compliance that were not applicable on this inspection* for details.

6.0 Inspection Findings – Mental Health Act 2001

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

7.0 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

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually. There was a separate policy on the management of aggression and violence. The policy included the provision of information to the resident, and it identified who can initiate physical restraint. The policy did not detail who may carry out physical restraint.

Training and Education: The approved centre maintained a written record which indicated that not all personnel involved in physical restraint had read and understood the policy or had undertaken the required mandatory training.

Monitoring: The approved centre forwarded the relevant annual report to the MHC.

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

Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint. In each episode examined, the resident's next of kin was informed about the physical restraint. In all three physical restraint episodes, the resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

However, in one episode of physical restraint a security guard was involved in the restraint of the resident under the guidance and supervision of multi-disciplinary team members. This exceptional event was not consistent with the approved centres policies on physical restraint or on the management of aggression and violence.

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

The approved centre was not compliant with this code because:

(a) The policy did not address who may carry out physical restraint 9.2(a).
(b) Not all personnel involved in physical restraint had read and understood the policy, 9.2(b).
(c) Not all personnel involved in physical restraint had undertaken the mandatory training, 10.1(e).

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 a series of separate written policies in relation to admission, transfer, and discharge. The admission and re-admission assessment policy was last reviewed in February 2019, the transfer to another approved centre or healthcare facility was last reviewed in January 2018, and the discharge process policy was last reviewed in March 2019. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident's family member/carer/advocate were involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment and other relevant information, such as work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

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

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to the general practitioner/primary care/community mental health team, within three days. A comprehensive discharge summary was issued within 72 hours, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or

social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Willow Grove Adolescent Unit, St Patrick's University Hospital

ID Number: AC0080

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Willow Grove Adolescent Unit, St Patrick's University Hospital
James' Street
Dublin 8

Approved Centre Type:
Child and Adolescent Mental Health Care

Most Recent Registration Date:
30 April 2019

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
n/a

Inspection Team:
Dr Enda Dooley, MCRN004155, Lead Inspector
Sarah Moynihan
Susan O'Neill

Inspection Date:
11 – 14 June 2019

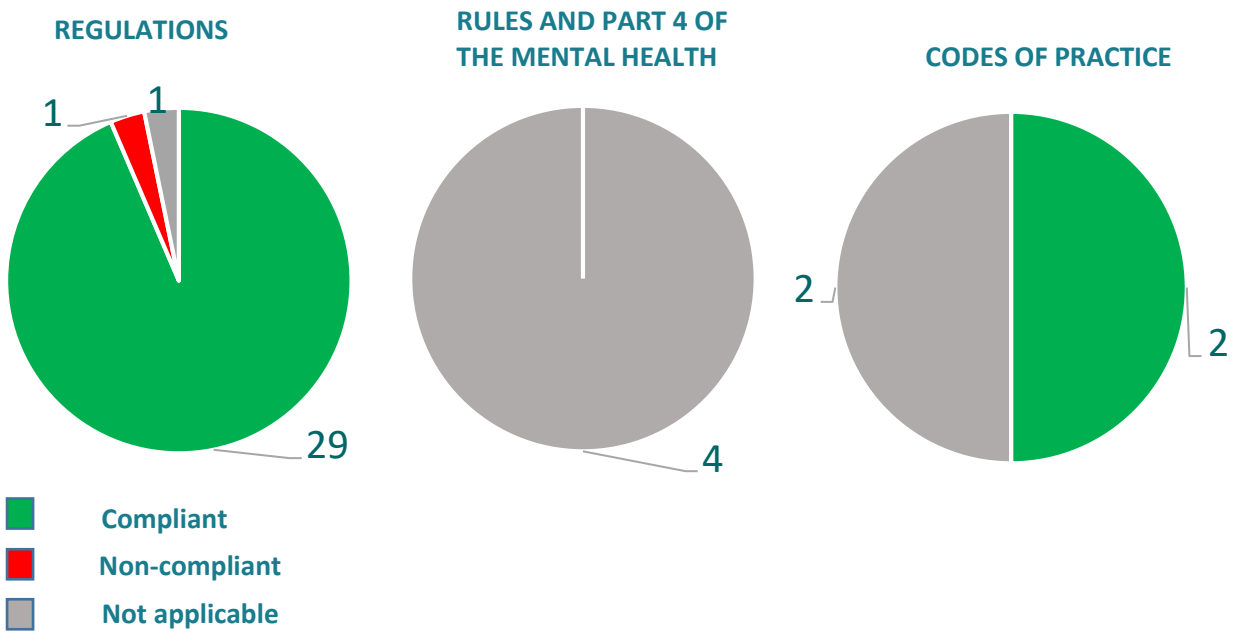
Inspection Type:
Announced Annual Inspection

Previous Inspection Date:
25 – 28 September 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
<<** – ** Month 2019>>

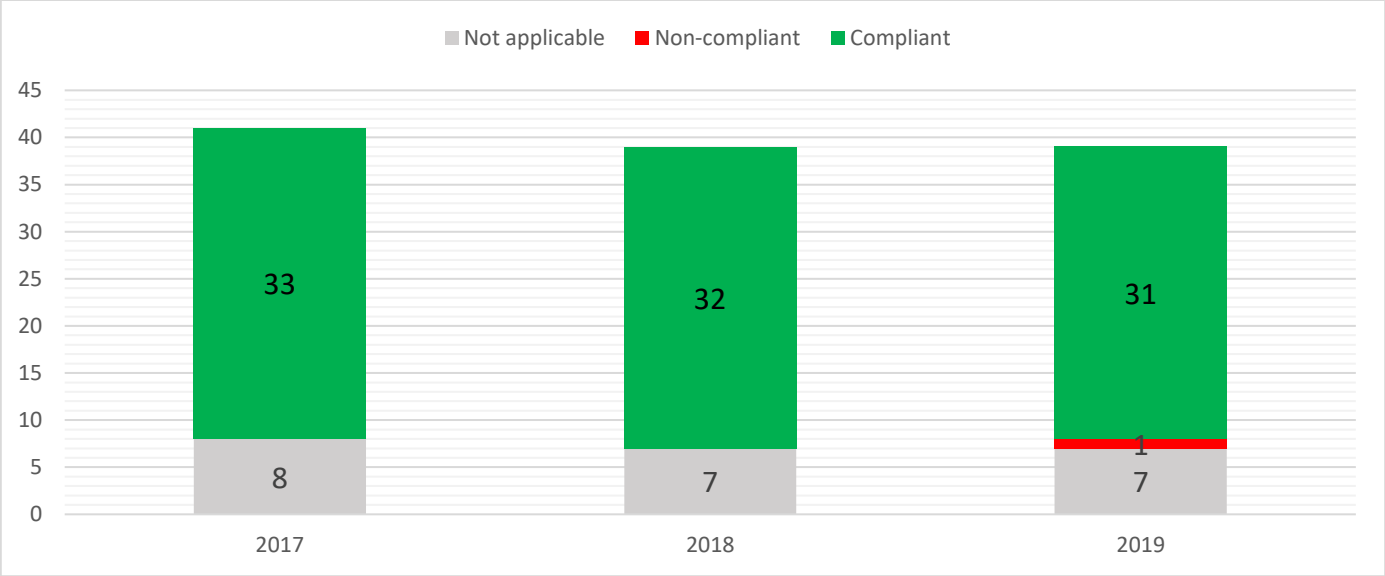
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

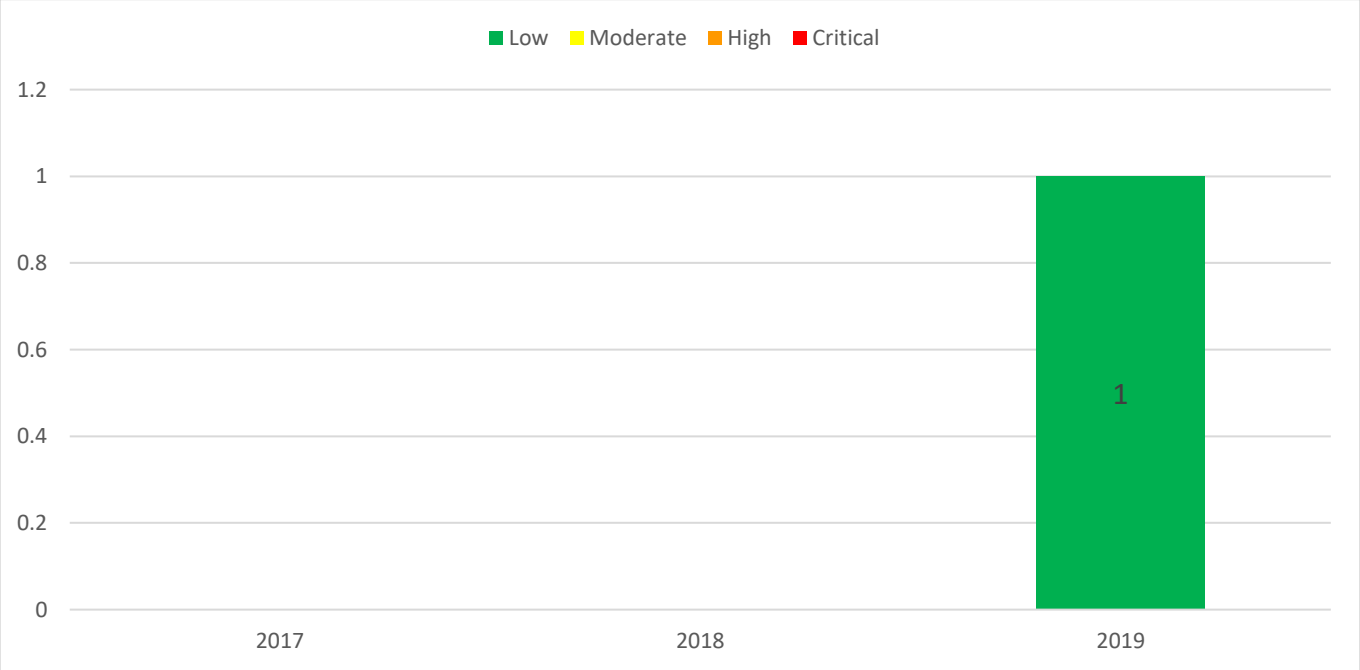
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



1.0 Overview of the Approved Centre

1.1 Description of approved centre

Willow Grove Adolescent Unit (WGAU) was a dedicated, standalone located within the grounds of St. Patrick's Hospital and forming part of St. Patrick's Mental Health Service (SPMHS). The unit operated independently to the adult service. It provided treatment to young people aged from 12 to 17 from all over Ireland.

The unit had accommodation for up to 14 young people and plans are in development to build a further unit, adjacent to and attached to the existing Willow Grove which would bring accommodation up to 27 beds when completed. All admissions to Willow Grove were planned. All bedrooms were single and included en suite and shower facilities. The unit had adequate therapeutic and communal areas and young people had access to an adjacent gym and outdoor recreational facilities. There was a school facility attached to the unit. At the time of this inspection the school facility was closed for summer holidays.

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

Resident Profile	
Number of registered beds	***14***
Total number of residents	**10**
Number of detained patients	0
Number of wards of court	0
Number of children	N/A
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

1.2 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.

2.0 Compliance

2.1 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 in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 28: Register of Residents	✓		✓		✗	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.

2.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programmes
Regulation 17: Children's Education
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 22: Premises
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines
Regulation 25: Use of Closed Circuit Television
Regulation 26: Staffing

Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

2.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
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 was not an adult centre, 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.

3.0 Service-user Experience

- 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.

Five resident of Willow Grove met with the inspectors. In addition, four resident questionnaires were returned. The residents commented positively on their interaction and support from staff. Meals were attractive and well presented. Bedrooms were comfortable though some residents found night observation somewhat obtrusive. The one issue of concern raised by residents was the lack of access to outdoor recreation on a regular basis. With the permission of the residents this matter was raised with management who undertook to review processes to seek to improve access.

4.0 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 May 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs, including residents' names, dates of birth, photographs, and addresses. A resident's photograph and name were used for identification purposes before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Identifiers appropriate to residents' communication abilities were used, and were person-specific. A system was in place to alert staff in the case that two or more residents had 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 **Excellent**

(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 nutritional care, which was last reviewed in March 2019, and policies in relation to therapeutic meal orders and patient meal orders, which were each reviewed in June 2018. The policies collectively addressed all of the requirements of the *Judgment Support Framework.*

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

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 in the approved centre were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, with residents having at least two choices for meals, along with hot daily meals. Residents had access to safe, fresh water, and hot and cold drinks were provided. At the time of the inspection, no resident was on a modified consistency diet, but all regular food was presented in an attractive and appealing manner.

An evidence-based nutrition assessment tool, the St. Andrew's Nutritional Screening Instrument, was used. Weight charts were implemented, monitored, and acted upon for residents, where appropriate. Residents, their next of kin, representatives, and family were educated about residents' diets, specifically in relation to any contraindications with medication. A sessional dietitian was employed by the service, who, where necessary, assessed the nutritional and dietary needs of the residents, and addressed these needs in the residents' individual care plans. The needs of residents identified as having specific nutritional requirements were regularly reviewed by the sessional dietitian, and intake and output charts were maintained, where required.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in June 2018. The policy addressed all of the requirements of the *Judgment Support Framework.*

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

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

Evidence of Implementation: Food was prepared in the approved centre in a manner that reduced the risk of contamination, spoilage, and infection. Catering areas and associated catering and food safety equipment were appropriately cleaned; hygiene was maintained to support food safety requirements. Appropriate hand-washing areas were provided for catering services, and appropriate protective equipment was used throughout the catering process. Residents were provided with crockery and cutlery that addressed their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. A record of residents wearing nightclothes during the day was maintained and monitored.

Evidence of Implementation: Residents were supported to keep and use their own personal clothing, and each resident had an adequate supply of individualised clothing. Residents' clothing was clean and appropriate to their needs. When necessary, residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Unless otherwise specified in their individual care plans, residents changed out of nightclothes during daylight hours.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies in relation to residents' personal property and possessions. The policy relating to property storage was last reviewed in August 2018; the policy relating to service user property was last reviewed in September 2018; and the policies relating to access to clothing and belongings, and to processing patient property, were last reviewed in March 2017. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The centre maintained a record of each resident's property and a copy as provided to the resident. Residents were facilitated to retain control of their own property subject to the operational requirements of the approved centre.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities, appropriate to the resident group profile on weekdays and during the weekend. Information on the types and frequency of activities was available in an accessible format, with posters visible throughout the unit. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement, and recreational activities were discussed at daily community meetings. Records of attendance were documented in residents' individual clinical files.

Opportunities were provided for indoor exercise, in communal areas and a gym, and outdoor exercise, in a garden and a tennis court. Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Residents were free to decide whether to partake in or abstain from participating in activities, and their decisions were respected and documented, where appropriate. The recreational activities provided by the approved centre were appropriately resourced.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in May 2019. There was also a policy relating to chaplaincy in the approved centre, which was last reviewed in September 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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, with facilities being provided for religious practice, insofar as was practicable. Residents had access to local religious services and were supported by staff to attend, if appropriate. Residents also had access to multi-faith chaplains. Care and services were respectful of 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 abstain from or observe religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policies and procedures in relation to visits. The policy relating to service user visitors was last reviewed in May 2018, and the policy relating to visiting children was last reviewed in May 2017. The policies and procedures included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Visiting times were appropriate and reasonable, and were publicly displayed at reception, on the ward, and in information booklets given to the residents. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Justifications were documented in the case that there were restrictions on visiting residents. Clinical files documented the names of visitors that residents did not wish to see.

A separate visitors' area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, to others, or a health and safety risk. The visiting area was appropriate for visiting children. To ensure their safety, children were required to be accompanied at all times, and this was communicated publicly to relevant individuals.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to resident communication, alongside numerous supporting policies. The policy were last reviewed in March 2017. The policy, procedures, and supporting policies included all of the requirements of the *Judgment Support Framework.*

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

Monitoring: 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, e-mail, internet, fax, and telephone, unless otherwise risk-assessed. Individual risk assessments were completed and documented in relation to any risks associated with residents' external communications. The clinical director, or a senior member of staff designated by the clinical director, would only examine incoming and outgoing resident communication if there was reasonable cause to believe that the communication could result in harm to the resident or to others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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 series of written operational policies and procedures in relation to the implementation of resident searches. The Service User Searches Policy was last reviewed in March 2017. The policies and procedures addressed all of the requirements of the *Judgment 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 policies. Relevant staff interviewed were able to articulate the searching processes, as set out in the policies.

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: The clinical file of one resident who was searched was inspected. Searches were only implemented for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches. The request for consent and the received consent were documented for every search of a

resident and every property search. General written consent was sought for environmental searches. When consent was not received, the process relating to searches without consent was implemented.

The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why. Policy requirements were implemented when illicit substances were found during a search.

At least two clinical staff were in attendance at all times during a search. A written record of every search of a resident, and of every property search, was available, including the reason for the search, the names of both staff members who undertook the search, and the details of who was in attendance.

The registered proprietor ensured that there was a minimum of two appropriately qualified staff in attendance at all times when searches were being conducted. Additionally, the registered proprietor ensured that all searches were undertaken with due regard to the resident's dignity, privacy, and gender.

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 14: Care of the Dying

COMPLIANT

(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 written operational policies and protocols in relation to care of the dying. The policies were last reviewed in August 2018 and January 2019, respectively. The policies and protocols included all of the requirements of the *Judgment Support Framework.*

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

As there had been no deaths since the last inspection, only the processes and training and education pillars were inspected against.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Ten ICPs were reviewed on inspection. Each resident was initially assessed at admission, and an initial care plan was completed to address the immediate needs of each resident. An ICP was developed by the MDT following a comprehensive assessment of each resident, within seven days of admission.

Each ICP was a composite set of documents, maintained electronically on an internal eSwift system, and also stored within the residents' clinical files. The ICPs were identifiable and uninterrupted, and were not amalgamated with progress notes. Each ICP identified the residents' goals, treatment, care, and the resources required to meet the person's needs, including the frequency and responsibilities for the implementation of care and treatment. Each ICP included a risk management plan, and, where deemed appropriate, a preliminary discharge plan.

Each ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Residents completed a young person's care plan review sheet prior to each ICP meeting. Residents did not attend ICP meetings, but ICPs were reviewed by the MDT, and the resident and their representatives were informed of any changes the following day. Care planning documentation was updated following ICP meetings, as indicated by the residents' changing needs, conditions, circumstances, and goals.

Residents had access to their ICPs, and were informed of any changes being made. In the situation where a resident declined or refused a copy of their ICP, the reason was documented.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

(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 March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The range of services and programmes provided in the approved centre was 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 appropriate and met the assessed needs of the residents, as documented in their individual care plans (ICPs), and their implementation was consistent with that outlined in the policy. The therapeutic services and programmes offered by the approved centre were evidence-based, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of the residents. Residents were provided with a list of all therapeutic services and programmes provided in the approved centre.

Resources and facilities to provide therapeutic services and programmes were adequate and appropriate to requirements. The approved centre had a separate dedicated therapeutic room containing facilities and space for individual and group therapies. A record of participation and engagement in, and outcomes achieved through, therapeutic services or programmes was maintained in residents' ICPs.

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 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

INSPECTION FINDINGS

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

Training and Education: Relevant staff had been trained on the policy relating to children's education and its implementation throughout the approved centre. Individual providers of educational services on behalf of the approved centre were qualified in line with their roles and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

Monitoring: A record was maintained of the attendance of child residents at internal and external educational services.

Evidence of Implementation: Child residents were assessed in relation to their educational requirements on admission to the approved centre, which included engaging with educational authorities and local education providers, as appropriate. Appropriate facilities and personnel resources were available, and child residents were supported to access external education services. The education provided by the approved centre was reflective of the required educational curriculum, as appropriate to the individual child resident. Where child residents were managing a transition, such as changing school or entering a higher level of education, suitable additional support was provided, especially in the lead up to discharge from the unit. Recommendations on optimal conditions for child residents to complete exams were provided by the multi-disciplinary team, and support was provided immediately after an exam and upon return to the unit, where applicable.

Educational provisions available within the approved centre were effectively communicated to child residents and their representatives. At the time of the approved centre's assessment, there was no school in operation, due to annual school holidays; however, during the academic year, timetabling of activities was undertaken on a daily basis. Attendance by child residents at the approved centre's educational services were documented, including reasons for non-attendance. The approved centre maintained comprehensive records of each child resident's educational history in the resident's individual care plan.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of a resident who was transferred from the approved centre in an emergency situation was inspected. A documented assessment of the resident was completed prior to transfer and provided to the receiving facility, including an individual risk assessment relating to the transfer, and the resident's needs. Verbal communication and liaison took place between the approved centre and the receiving facility prior to any transfer taking place, which included the reasons for transfer, the resident's care and treatment plan, those needs and risk identified in the risk assessment, and the resident's accompaniment requirements. Documented parental consent for the resident's transfer was available.

Communication records with the receiving facility were documented and available on inspection. Information was sent to a named individual at the receiving facility accompanying the emergency transfer. This including a letter of referral, a resident transfer form, and details of medications required during the transfer and at any point thereafter, and full and complete written information for the resident was sent once the transfer had been completed.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in May 2019. The medical emergencies policy was last reviewed in October 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley, and staff had access to an Automated External Defibrillator (AED), at all times. Twice-weekly checks were performed on the resuscitation trolley and on the AED, and directly after use in the case of a medical emergency. Records of any medical emergency within the approved centre were available, and of the care provided to mitigate the emergency, which the senior member of staff in attendance at the medical emergency was required to complete within 24 hours.

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; residents' ongoing needs were assessed and monitored at least every six months, as indicated by the residents' specific needs.

The clinical file of one resident who was in the approved centre for at least six months was examined in relation to the six monthly general health assessment. The health assessment included: a physical examination; the resident's family history; BMI, weight and waist circumference; smoking status; nutritional status; medication review; and dental health. At the time of the inspection, one resident was on antipsychotic medication, and an annual assessment of the resident's: fasting glucose; blood lipids; ECG; and prolactin was undertaken.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. There was a localised policy on tobacco use, and the approved centre provided ongoing support to encourage smoking cessation, supplying nicotine replacement therapy where necessary.

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 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies and procedures in relation to the provision of information to residents:

- Service user and family education journey, last reviewed in March 2017.
- Accessing interpreting services, last reviewed in June 2017.
- Service user access to communication facilities, last reviewed in March 2017.

The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: An information booklet, in the format required to support residents' needs, was provided to residents and their representatives at admission. The booklet was written in a clear and simple manner, and contained details on care, services, housekeeping arrangements, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, residents' rights, and details of the multi-disciplinary team.

Residents were provided with written and verbal information relating to their diagnosis unless it was determined by the treating psychiatrist that provision of such information would be prejudicial to the resident's physical or emotional wellbeing. A variety of medication and diagnosis-related information, including potential side effects and risks, was available and provided to residents as appropriate.

Information was accessible and residents had access to interpreting and translation services as required. Information documents relating to medication were obtained from the Choices Medication website. Documentation provided by or within the approved centre were reviewed and approved prior to use.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Approved centre staff dressed appropriately and had an appropriate demeanour, and ensured that residents were always wearing clothing that respected their privacy and dignity. Staff used discretion when discussing medical conditions or treatments, communicated with residents respectfully, and addressed residents by their preferred name.

All bedrooms and other rooms had opaque doors to protect privacy, all doors had blinds, and external windows had curtains. Noticeboards did not contain resident names or other identifiable information. En suite bathroom doors' locks had an override function that could be activated when a risk had been identified. Staff sought residents' permission before entering bedrooms, as appropriate. Once residents' bedroom doors were closed, the doors locked and could only be opened from the inside, or by an authorised member of staff with special key fob access.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(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 number of written policies in relation to its premises, all of which had been reviewed within an appropriate time frame. The policies included all of the requirements of the *Judgment Support Framework.*

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

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

Evidence of Implementation: Residents had room to move about and had access to personal space, appropriately-sized communal rooms, and a garden. The approved centre was sufficiently warm, and all areas were sufficiently ventilated. Private and communal areas were suitably sized and furnished in order to reduce excessive levels of noise. The lighting in the communal rooms were of a sufficient level to facilitate reading and other activities. There were suitable furnishings to facilitate resident independence and comfort. Hazards were minimised to the lowest possible level, and ligature points had been mitigated to the lowest practicable level.

The approved centre was kept in a good state of repair both internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, of which records were maintained. There was a cleaning schedule implemented in the approved centre, which was clean, hygienic, and free from offensive odours. Rooms were heated

centrally, with pipe work and radiators guarded. Heating could be safely controlled in the resident's own rooms, in compliance with health and safety guidance and building regulations. Any issues that were identified in relation to the premises could be communicated through the appropriate maintenance reporting process.

The approved centre had dedicated therapy and examination rooms, a sluice room, a designated laundry room, and an appropriately-sized lift. Toilets were accessible and clearly marked, and were close to day and dining areas. There was a sufficient number of toilets and showers relative to the number of residents. All resident bedrooms were sized appropriately to resident needs. Remote or isolated areas of the approved centre were monitored both manually and via CCTV.

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 23: Ordering, Prescribing, Storing and Administration of Medicines

COMPLIANT

Quality Rating **Excellent**

(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 number of written policies in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in an appropriate time frame. The policies included all of the requirements of the *Judgment 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 policies. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administration of medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. This training was documented.

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

Evidence of Implementation: Ten MPARs were reviewed by the inspectorate. All entries were legible. A prescription was not altered where a change was required; rather, the prescriber wrote a new prescription. Two appropriate resident identifiers were used in all cases. A record of any allergies or sensitivities to any medications, including if the resident had no allergies, was made. MPARs included details of the frequency of administration, the amount to be given, the generic name for the medication, the administration route, and the microgram dose written out without abbreviation. All medication, including scheduled controlled drugs, were administered by a registered nurse or a registered medical practitioner. Details were entered into the controlled drug book, and the controlled drug balance corresponded with the balance recorded in the controlled drug book. MPARs included the Medical Council Registration Number of every medical practitioner prescribing medication, and MPARs were electronically signed by the medical practitioner after every entry.

Medication was administered in accordance with the directions of the prescriber, and any advice provided by the resident's pharmacist regarding the appropriate application of the product were adhered to. Good hand hygiene techniques were used when medication was being dispensed. The expiration date of the medication was checked prior to administration, and expired medications were not administered. When a resident's medication was withheld, or where a resident refused medication, this was documented in the MPAR and the resident's clinical file, and was communicated to medical staff. Where a risk assessment

had been undertaken, residents could self-administer medication. Any change to initial risk assessments were recorded, and arrangements for the self-administration of medication were kept under review. Medications for self-administration were labelled individually and appropriately.

Medication was stored in the appropriate environment. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Areas used for medication storage were not also used to store food or drink. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests, and free from spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules. An inventory of medications was conducted on a monthly basis, checking the name and dose, quantity, and expiry date of the medication. Medications that were no longer required, which were past their expiry date, or had been dispensed to a resident but were no longer required, were stored in a secure manner, segregated from other medication, and returned to the pharmacy for disposal.

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 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 large number of written operational policies and procedures relevant to the health and safety of residents, staff, and visitors, in particular:

- Health and Safety Policy, which was last reviewed in 2019.
- Corporate Safety Statement, which was last reviewed in February 2018.

The policies and the safety statement included all of the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in August 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre.

Training and Education: All relevant 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 use of CCTV, as set out in the policy.

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. There were clear signs in prominent positions where CCTV cameras were located. CCTV cameras were incapable of recording or storing a resident's image. CCTV cameras did not transmit images other than to a monitor that was placed in the nurses' station, and were viewable solely by the health professionals responsible for the resident. The usage of CCTV was disclosed to the Mental Health Commission.

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 26: Staffing

COMPLIANT

Quality Rating **Excellent**

(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 multiple written policies and procedures in relation to its staffing requirements. Both the staffing policy and the general recruitment policy were last reviewed in May 2019. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: 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 given time during the day or night, was maintained in the approved centre. Staff were appropriately qualified to do their job, and an appropriately qualified member of staff was on duty and in charge at all times.

Staff were recruited for the approved centre in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment. All staff, including permanent, contract, and volunteers, were vetted in accordance with the approved centre's recruitment, selection, and appointment policy and procedure. There was a staffing plan that addressed the skill mix, competencies,

number and qualifications of staff, and took into account the size and layout of the approved centre and the assessed needs of the resident group profile. Annual staff training plans had been completed to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed for all new members for staff. All staff were trained in fire safety, Basic Life Support, Management of Violence and Aggression, the Mental Health Act 2001, and Children First. Staff had also received a range of other training, including manual handling, infection control and prevention, resident rights, risk management, and recovery-centred approaches to mental health care and treatment.

Opportunities were made available to staff by the approved centre for further education; these opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained, competent individuals, and facilities and equipment were available for in-service training.

Staff training was documented and staff training logs were maintained. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

The following is a table of staff mandatory training levels in the approved centre -

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (20)	20	100%	20	100%	20	100%	20	100%	20	100%
Consultant Psychiatrist (4)	4	100%	4	100%	4	100%	4	100%	4	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%	3	100%

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

Ward or Unit	Staff Grade	Day	Night
Willow Grove	CNM3	1 (M-F)	0
	CNM2	1 (M-F)	0
	CNM1	1	0
	RPN	5-6	3
	Occupational Therapist	1	0
	Social Worker	1	0
	Psychologist	3	0

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

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 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of policies in relation to the maintenance of records, all of which had been reviewed within an appropriate time frame. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: All resident clinical files had a two unique patient identifiers, were secure, up to date, in good order and maintained in line with national guidelines and legislative requirements. Records were kept electronically and were easy to find through the eSwift system. A record was maintained for every resident who was assessed or provided with care in the approved centre. Only authorised staff could access data and make new entries, and residents could access records in line with relevant legislation. Staff had access to the information required to carry out their job.

Records were maintained appropriately, including being factual, consistent, reflecting the residents' current status, and used date and time (using the 24-hour clock). A registered nurse or clinical supervisor validated all entries made by student nurses or training staff. Where errors were made, they were

corrected appropriately. Where a member of staff made a referral, or consulted with a colleague, this person was clearly identified using their full name and title. Information or advice was given over the phone was documented.

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

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

Regulation 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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 that was not accurate and up to date. Specifically, in the case of one resident, the admission date stated on the Register of Residents was not consistent with the actual admission date. The register of residents contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was non-compliant with this regulation because the admission date specified on the Register was not accurate in all cases. Consequently, the Register was not accurate, 28(1).

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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 May 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed had been trained on approved operational policies and procedures.

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, including service users. Operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines, and were appropriately approved and communicated to all relevant staff. Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained, but removed from possible access by staff. Generic policies were appropriate to the resident group profile and the approved centre. Where generic policies were used, the approved centre had a written statement to this effect. Generic policies were reviewed at least every three years.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints, which was last reviewed in May 2019. The policy and procedures addressed all of the requirements of the *Judgment Support Framework*, including the process for managing complaints, which included 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: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person available to the approved centre who was responsible for dealing with all complaints. A consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make verbal, written, electronic, and telephonic complaints, as well as by using feedback or suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates in order to facilitate the participation of the resident and their representative in the complaints process. The approved centre's management of complaints was well-publicised, and accessible to residents and their representative, including the provision of information about the complaints process at admission. The complaints procedure, including the contact details of the nominated person, were publicly displayed.

All complaints, made in any manner, were investigated promptly, and handled appropriately and sensitively. The registered proprietor ensured that the quality of service, care and treatment were of a sufficiently high level to avoid the situation where a resident would need to make a complaint. Minor complaints were addressed appropriately, recorded in the complaints log, and, where they could not be addressed locally, would be referred to the nominated person. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded, and kept distinct from the resident's individual care plan.

Time frames were provided for: responding to the complainant following receipt of the complaint; the investigation period; and the required resolution of complaint. Where time frames were not achieved, or where further investigation time was required, this was communicated to the complainant. The complainant was informed promptly of the outcome of the complaint investigation, and details of the appeals process were made available to them. All information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

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 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

(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 number of written policies in relation to risk management and incident management procedures, which had all been reviewed within an appropriate time frame. The policies addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. 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 policies. All staff interviewed were able to articulate the risk management processes, as set out in the policies. All training was documented.

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

Evidence of Implementation: The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in risk registers. Structural risks, including ligature points, were removed or effectively mitigated. A plan was implemented to reduce risks to residents while works on the premises were ongoing. The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes.

Individual risk assessments were completed prior to and during the following: physical restraint; admission; transfer; discharge; and in conjunction with medication requirements or administration. Multi-disciplinary teams, residents, and their representatives were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and any recommended actions. The approved centre provided twice yearly summary reports of all incidents to the Mental Health Commission, with the information provided anonymous at a resident level. The person with responsibility for risk management reviews aggregate incident data for any trends or patterns ongoing in the service. The approved centre had an emergency plan that specified responses to possible emergencies, and included an emergency plan which incorporated evacuation procedures.

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 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 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 in the reception area.

The approved centre was compliant with this regulation.

5.0 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 2.3 Areas of compliance that were not applicable on this inspection* for details.

6.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of Mental Health Act 2001 was not applicable to this approved centre at the time of the inspection. Please see *Section 2.3 Areas of compliance that were not applicable on this inspection* for details.

7.0 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 September 2018. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- The child protection process in the case that a child is restrained.

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.

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

Evidence of Implementation: Physical restraint was used in relation to child residents. Child protection policies and procedures were in place. The policies addressed appropriate training for staff in relation to child protection.

Three episodes of physical restraint were reviewed on inspection. In all cases, physical restraint use was rare, in exceptional circumstances, and in the best interests of the resident, where the resident posed an immediate threat of serious harm to themselves or others. Physical restraint was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered, and was based on a risk assessment. Orders for physical restraint did not last longer than 30 minutes, and were initiated by a registered medical practitioner (RMP), registered nurse, or other member of the multi-disciplinary team (MDT).

Gender sensitivity and cultural awareness were applied in all cases. The consultant psychiatrist (CP), or the duty CP, was notified as soon as was reasonably practicable, and this was recorded in the residents' clinical files. A RMP completed a medical examination of the resident no later than three hours after the start of an episode of physical restraint. The residents were each notified of the reasons for, the likely duration of, and circumstances leading to the discontinuation of physical restraint, unless the information could have been prejudicial to the resident's mental health, well-being, or emotional condition. The clinical practice form was completed by the person initiating physical restraint no later than three hours after the conclusion of the episode, signed by the CP within 24 hours, and placed in the resident's clinical file.

In two of the three cases, a same sex staff member was present at all times during the episode of physical restraint; in the third case, the priority was the safety of the resident, as a matter of urgency. In all cases, the residents were afforded the opportunity to discuss the episode of physical restraint with members of the MDT as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in each resident's clinical file no later than two working days after the episode. The

parent or guardian of the child residents were informed of the episodes of physical restraint as soon as possible.

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, which were last reviewed in February 2019, January 2018, and May 2019 respectively. Collectively, they addressed all of the policy-related criteria for the codes 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: All admissions were on the basis of mental illness or mental disorder. Admission assessments were completed, and included an appropriate range of assessments. Residents' representatives were involved in the admission process. A key worker system was in place.

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

Discharge: The approved centre maintained discharge plans, which included documented communication with the relevant health professionals, and included a reference to early warning signs of relapse and risks, a follow-up plan, and an estimated date of discharge.

Discharge meetings were attended by residents and their representatives, their key worker, and relevant members of the multi-disciplinary team. Discharge assessments addressed medical and informational needs, and discharges were coordinated by a key worker.

In all cases reviewed during inspection, a comprehensive discharge summary was issued within 72 hours. Discharge summaries included details such as names and contact details of key contact points, follow-up arrangements, and medical information. In all cases, a timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: St. Edmundsbury Hospital Corrective and Preventative Action Plan

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10000728		**Not all personnel involved in physical restraint had undertaken the mandatory training, 10.1(e).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It has been reaffirmed with security staff that, in accordance with organisational policiy, only clinical staff trained in Crisis Prevention Intervention (CPI) Management of Actual and Potential Aggression (MAPA) training are permitted to initiate or carry out physical restraint	Continuous monitoring of individual incident reports of physical reatraint	Completed. No barriers identified	01/11/2019	Director of Nursing
Preventative Action	It has been reaffirmed with security staff that, in accordance with organisational policiy, only clinical staff trained in Crisis Prevention Intervention (CPI) Management of Actual and Potential Aggression (MAPA) training are permitted to initiate or carry out physical restraint	Continuous monitoring of individual incident reports of physical reatraint	Completed. No barriers identified	01/11/2019	Director of Nursing
Reason ID : 10000729		**Not all personnel involved in physical restraint had read and understood the policy, 9.2(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It has been reaffirmed with security staff that, in accordance with organisational policiy, only clinical staff trained in Crisis Prevention Intervention (CPI) Management of Actual and Potential Aggression (MAPA) training are permitted to initiate or carry out physical restraint	Continuous monitoring of individual incident reports of physical aggression	Completed	01/11/2019	Director of Nursing

Preventative Action	It has been reaffirmed with security staff that, in accordance with organisational policiy, only clinical staff trained in Crisis Prevention Intervention (CPI) Management of Actual and Potential Aggression (MAPA) training are permitted to initiate or carry out physical restraint	Continuous monitoring of individual incident reports of physical aggression	Completed	01/11/2019	Director of Nursing
Reason ID : 10000730		**The approved centre policy did not address who may carry out physical restraint 9.2(a)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Policy NUR 0031 Physical Restraint has been updated to identify who may initiate and carry out a physical restraint. It now states, "4.1.2 Physical restraint may only be initiated and carried out by clinical staff appropriately trained in the Crisis Prevention Intervention (CPI) Management of Actual and Potential Aggression (MAPA) training programme".	Policy NUR 0031 Physical Restraint was updated and reviewed and approved by the St. Patrick's Mental Health Services Clinical Governance Committee	Completed	16/01/2020	Adam Kavanagh, Programme Manager for Clinical Governance
Preventative Action	Policy NUR 0031 Physical Restraint has been updated to identify who may initiate and carry out a physical restraint. It now states, "4.1.2 Physical restraint may only be initiated and carried out by clinical staff appropriately trained in the Crisis Prevention Intervention (CPI) Management of Actual and Potential Aggression (MAPA) training programme".	Policy NUR 0031 Physical Restraint was updated and reviewed and approved by the St. Patrick's Mental Health Services Clinical Governance Committee	Completed	16/01/2020	Adam Kavanagh, Programme Manager for Clinical Governance

Appendix 2: Willow Grove Adolescent Unit Corrective and Preventative Action Plan

Regulation 28: Register of Residents					
Reason ID : 10000731		**The admission date specified on the Register was not accurate in all cases. Consequently, the Register was not accurate, 28(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The error on the Register of Residents has been corrected	Action completed, confirmed by inspection of register of residents	Completed	17/01/2020	ICT Clinical Informatics Lead
Preventative Action	It has been communicated to all staff that if they discharge a Service User from the electronic health record system in error, they must contact the ICT team for support at the time of the incident occurring	The electronic health record now enables staff to run a report on a nightly basis which provides the ability to check data related to admissions, transfers, discharges, and temporary therapeutic leave electronically directly from eSwift.	Completed. No barriers identified	29/07/2019	CNM3

Appendix 3: 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.

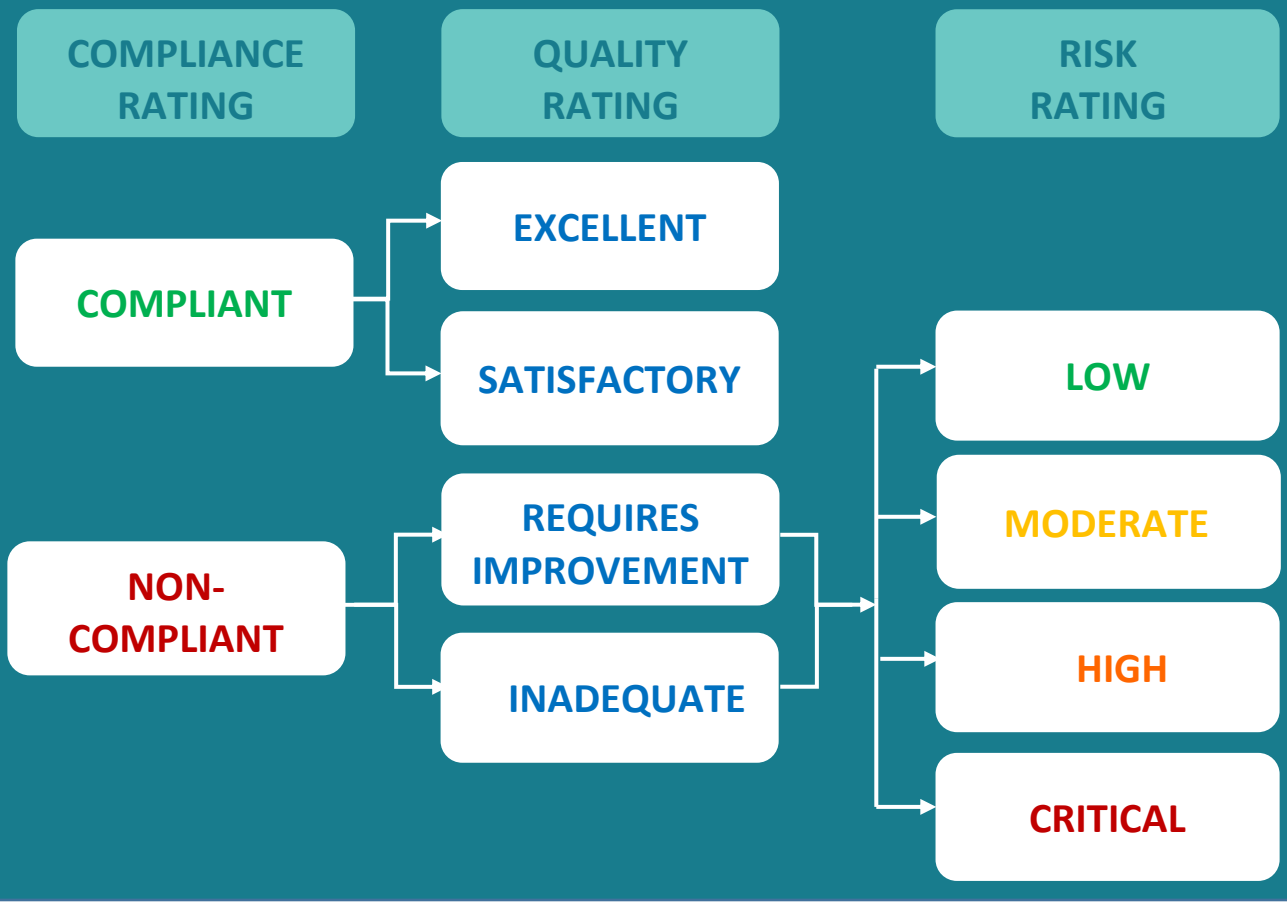
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly,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