# Aidan's Residential Healthcare Unit

Annual Inspection
Report 2023

*Promoting Quality, Safety and Human Rights in Mental Health*

# AIDAN'S RESIDENTIAL HEALTHCARE UNIT

St. Patrick's Hospital, St. John's Hill, Waterford.

**Date of Publication:**
02 April 2024

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## 2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

**Conditions Attached:**
None

**Most Recent Registration Date:**
2 April 2023

**Registered Proprietor:**
HSE

**Registered Proprietor Nominee:**
Ms Anne Donaghey, Head of Services, CHO 5 Mental Health Services

**Inspection Team:**
Sarah Jones, Lead Inspector
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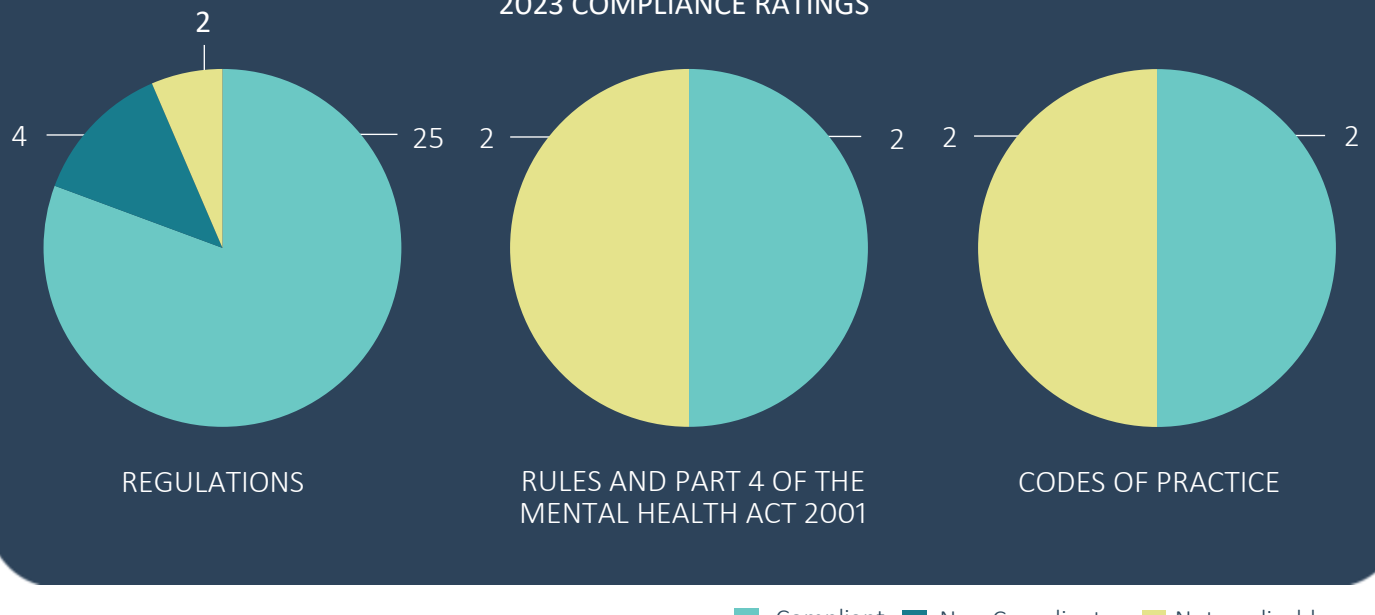
**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Inspection Date:**
25 – 27 July 2023

**Previous Inspection date:**
6 – 9 September 2022

**Inspection Type:**
Announced Annual Inspection

2023 COMPLIANCE RATINGS

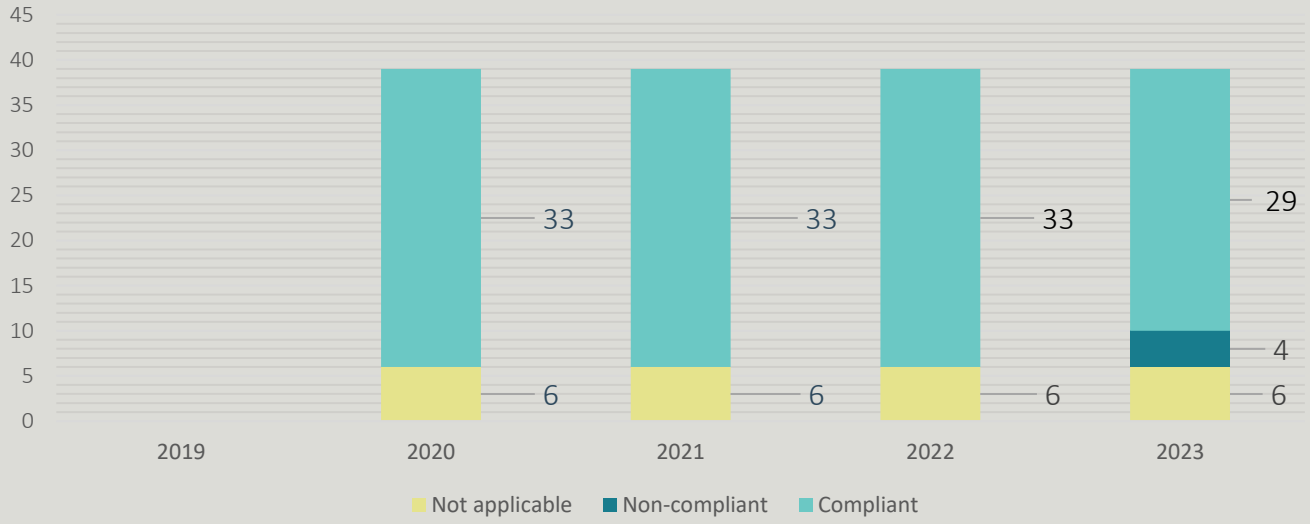


## RATINGS SUMMARY 2019 – 2023

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

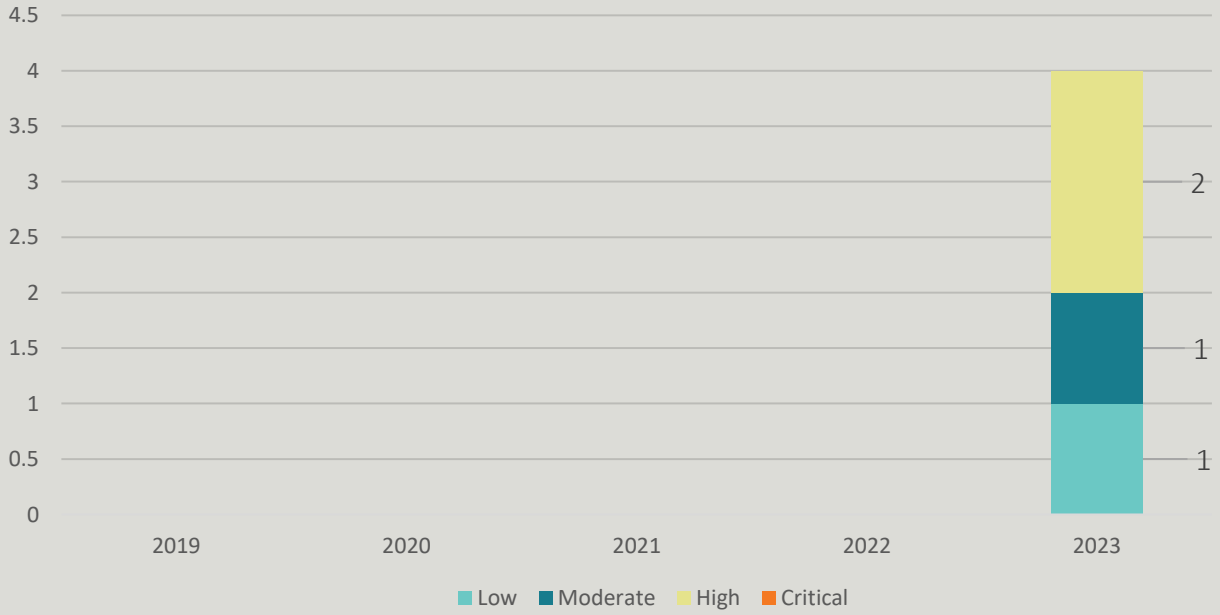
**Please note:** The approved centre opened for the first time in 2020.

### CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023




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 2019 – 2023



# Contents

# 1.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

## In brief

St Aidan's Residential Healthcare Unit was located in Waterford Residential Care Centre, Waterford City. St Aidan's opened for the first time in 2020 and provided three service types to the catchment area of Waterford and South Kilkenny, the services were: psychiatry of later life, continuing mental health care/long stay, and mental health rehabilitation. The registered proprietor is the Health Service Executive (HSE). At the time of the inspection, the approved centre had a bed capacity of 20 and accommodated 13 residents.

| Compliance Summary | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| % Compliance | N/A | 100% | 100% | 100% | 88% |

## Conditions to registration

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

## Ongoing escalation and enforcement actions at time of inspection

None.

## Escalation and enforcement actions commenced following this inspection

None.

## Safety of people in the approved centre

**The approved centre demonstrated that they provided safe care in the following areas:**

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.

- ***Number of registered nurses in the approved centre*:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Ligature anchor points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Infection control*:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Clinical Risk: Medications:*** While there were appropriate practices for storing medications there was not suitable practices in relation to the ordering and prescribing of crushed medications: there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed. Also the medical practitioner did not document within the Medication, Prescription, and Administration Record (MPAR) the specific medications which were to be crushed.
- ***Access to essential information*:** The clinical files were not all in order and it was not easy to find essential information about the resident in the sample of clinical files inspected. Three residents' clinical files had loose pages, and one resident's clinical file had a loose page which was stored in the wrong section of the resident's clinical file.

## Appropriate care and treatment of residents

**The approved centre demonstrated that they provided appropriate care and treatment in the following areas:**

- **Appropriateness of environment:** The layout and the decoration of St. Aidan's Residential Unit was of high standard and met the needs of the residents.
- ***Initial assessments:*** All residents had a comprehensive initial assessment on admission.
- ***Physical assessment:*** Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) and there was evidence of significant engagement with residents in respect of their ICP. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, a clinical and counselling psychologist, and

a dietitian. There were regular multi-disciplinary team meetings to discuss residents' care plans. There was a social worker, occupational therapist and psychologist on the team.

- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan, a selection included: music therapy, and art and gardening.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Register of Residents:*** While the approved centre had a documented electronic register of all residents admitted, the discharge diagnosis was not completed on the register for four individuals.

## Respect for residents' privacy, dignity and autonomy

**The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:**

- ***Sleeping accommodation:*** Residents had their own single en suite bedroom.
- ***Interactions between staff and residents:*** Staff in the approved centre respected the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** Residents' dignity and privacy were respected.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical restraint and separately physical restraint were used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by mechanical means, and separately for each person physically restrained including information on attempts to reduce or eliminate the use of restraint for that person. The approved centre was compliant with the Code of Practice on Physical Restraint and with the Rule Governing Mechanical Restraint. Seclusion was not used in the approved centre.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

## Responsiveness to residents' needs

**The approved centre demonstrated that they were responsive to people's needs in the following areas:**

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: A selection included newspaper reading, walks in the garden, YouTube concerts, live music on a Tuesday, hand massage, Mass, movie night, nail painting and hair, and ball games.
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received. Residents felt the premises was nice, clean, comfortable and bright. All respondents reported they know who the multi-disciplinary team and keyworker were. *(Please refer to section 5.1 and section 5.2 for detailed service-user feedback).*

## Governance, Leadership and Accountability

**The approved centre had the following governance structures and processes in place:**

- ***Structure in place:*** The approved centre was part of Community Healthcare South East/Community Healthcare Organization 5 (CHO 5) and was governed under the Waterford/Wexford Mental Health Service.
- ***Leadership:*** The approved centre was part of Community Healthcare South East/Community Healthcare Organization 5 (CHO 5) and was governed under the Waterford/Wexford Mental Health Service. A Quality and Patient Safety Committee (QPSC) meeting was held monthly.
- ***Restrictive practices reduction:*** The approved centre had a reduction of restrictive practices strategy and was compliant with the Code of Practice on Physical Restraint and with the Rule Governing Mechanical Restraint. Seclusion were not used in the approved centre.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. There was a local risk register and applicable risks had been escalated to the relevant forum if necessary.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. Quality initiatives included live music sessions and seasonal family and friend social events such as the Spring Garden Event took place in the courtyard. *(Please refer to section 2.0 for full list of quality initiatives).*
- ***Policies:*** The approved centre policies were up to date.
- ***Staff training:*** All staff had received mandatory training. Clinical supervision was provided for medical, nursing and the health and social care professional groups.
- ***Complaints:*** There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.

- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Monthly resident-peer advocacy meetings and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** A representative from Peer Advocacy in Mental Health was available in person and online to the residents of the approved centre. Monthly resident's meetings took place in the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 97% over the last 4 years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risks:*** There was not suitable practices in relation to the ordering and prescribing of crushed medications.

# 2.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. Live music sessions were held weekly by Waterford Healing Arts to promote social engagement.

2. Traditional Irish music sessions were held weekly on a Wednesday.

3. Staff in partnership with families, created “All about me“ personalised folders for residents which detailed the persons story, their likes and dislikes and included photos of them and their loved ones.

4. Seasonal family and friend social events such as the Spring Garden Event occurred in the courtyard.

5. A “Big Reel” movement group commenced in February 2023 to support movement and social inclusion.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

Aidan's Residential Healthcare Unit was situated in Waterford Residential Care Centre, in Waterford City. At the time of the inspection three teams were referring into the approved centre. Two teams were psychiatry of later life and the third was a rehabilitation team. All residents were under the care of the psychiatry of later life teams at the time of inspection. The approved centre served the catchment area of Waterford and South Kilkenny. The approved centre had access to shared facilities with three other units in Waterford Residential Care centre. These facilities included a spacious entrance lobby, a multipurpose meeting room, a hair salon, an oratory and gardens.

The approved centre was a purpose-built modern facility which comprised of 20 ensuite single bedrooms. Each bedroom was spacious, with an en suite shower and toilet. All bedrooms were furnished with a TV, tracked hoist and had personal access to a shared courtyard. Each bedroom had cupboards and wardrobes which were lockable and there was a safe fitted in each room.

The approved centre was designed in a square and included its own central courtyard style garden. A second enclosed garden was also available to residents on the grounds of the approved centre. There was an activity room, sunroom, sitting room, communication room, kitchen and a dining room available to residents.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***20*** |
| **Total number of residents** | **13** |
| Number of detained patients | 6 |
| Number of wards of court | 0 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 11 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 3.2 Governance

The approved centre was part of Community Healthcare South East/Community Healthcare Organization 5 (CHO 5) and was governed under the Waterford/Wexford Mental Health Service. The wider Community Healthcare South East encompassed Kilkenny, Carlow, and South Tipperary.

The Waterford/ Wexford Executive Management Team (EMT) meeting and Waterford/Wexford Quality and Safety Executive Committee (QSEC) meeting were both held monthly. Other senior management meetings included a monthly business meeting and a bimonthly health and safety forum.

A Quality and Patient Safety Committee (QPSC) meeting was held monthly. Representation from medical, nursing and health and social care professionals who worked directly in the approved centre attended these meetings with the risk manager in attendance also. The Area Lead for Mental Health Engagement and a forum representative were also on this committee. Agenda items included mental health engagement and recovery, regulation and compliance, review of the risk register, clinical audit and quality improvement, risk management, staff training and escalation of items to the QSEC committee for discussion if required.

There were key personnel with responsibility for risk management working in the approved centre. The approved centre had a risk manager. The person with overall responsibility for risk was identified and known by staff. The approved centre had a local risk register and applicable risks had been escalated to the relevant forum if necessary. The risk register contained health and safety risks, clinical risks and corporate risks. All incidents had been appropriately reported and were reviewed for patterns and trends by the risk manager however the clinical risk of crushing specific medications was not adequately treated. The approved centre does not have a dedicated pharmacy service however the approved centre was able to consult with the pharmacy in University Hospital Waterford. The approved centre was provided with two guidelines for crushing medications for percutaneous endoscopic gastrostomy (PEG) feeding as a management guideline when deciding if a preparation of medication could be crushed. MPAR's where applicable, did not record the specific medications that were prescribed crushed but instead recorded a blanket statement on the front of the MPAR stating medications were to be crushed. This increased the risk of administrating medication via the wrong preparation. There was no specific consultation recorded in clinical files with the pharmacist about each of the medications in each of the MPAR’s, in relation to crushed medication.

There was an organizational chart defining key positions and lines of responsibility. The approved centre was adequately staffed. Core staff included nursing staff, health care assistants, psychologist and an occupational therapist. Governance questionnaires were completed by the heads of discipline and returned to the inspection team. The inspector spoke with each head of discipline as part of the inspection process. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical, nursing and the health and social care professional groups.

A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre. The representative provided a combination of in person and virtual support to the residents. Monthly resident's meetings took place in the approved centre. This provided an opportunity for residents to raise concerns or make suggestions. A review of the minutes for these meetings indicated that activity planning and requests from residents were discussed frequently at these meetings.

The process for making a complaint was publicly displayed and available to residents and family members. The details of the complaints officer were displayed in communal spaces throughout the approved centre and in an information booklet in each resident's bedroom. Formal complaints were dealt with by a

complaints officer who was not based in the approved centre. No formal complaints had been made since the previous inspection. Minor complaints were documented with clear actions and outcomes detailed.

## 3.3 Reporting on the National Clinical Guidelines

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

# 4.0 Compliance

## 4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2019 and 2023 and the relevant risk rating when the service was non-compliant:

**Please note:** The approved centre opened for the first time in 2020.

| Regulation/Rule/Act/Code | Compliance/Risk Rating | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | |
| Regulation 23: Medication | | | ✓ | | ✓ | | ✓ | | ✗ | High |
| Regulation 27: Maintenance of Records | | | ✓ | | ✓ | | ✓ | | ✗ | Moderate |
| Regulation 28: Register of Residents | | | ✓ | | ✓ | | ✓ | | ✗ | Low |
| Regulation 32: Risk Management Procedures | | | ✓ | | ✓ | | ✓ | | ✗ | High |

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

## 4.2 Areas 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 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. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre did not admit children, this code of practice was not applicable. |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | As the approved centre did not provide an ECT service, this code of practice was not applicable. |

# 5.0 Service-user Experience

## 5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engage 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.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health 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.

Three questionnaires were returned to the inspection team completed by family members or friends. All questionnaires indicated that the person, when admitted, staff explained to them what had happened in a way they could understand. Staff always gave information about the diagnosis, care, and treatment and all understood their care plan. Two individuals indicated they were always involved in setting goals whilst one individual stated they were sometimes involved.

All respondents reported they know who the multi-disciplinary team and keyworker were. Two individuals reported that if they had concerns, they were always able to discuss these with staff. One person reported they sometimes felt able to as soon as it was needed.

All respondents indicated that they felt there were enough activities during the day, had privacy and felt privacy and dignity were always respected. All individual reported their family or friend was able to communicate freely with them and they always felt safe within the approved centre.

When wishing to give feedback or to make a complaint, when not satisfied with the persons stay, all respondents indicated they were always able to speak with staff as soon as they needed to. One person indicated they did not know how to make a complaint.

On a scale of 1-10 with 1 being poor and 10 being excellent, all three people scored the approved centre 10 respectively.

Comments made within the questionnaires reported the service was “spotless, really happy with the care the person is receiving, food looks delicious” and “I am very safe and well looked after”.

## 5.2 Advocacy

The approved centre had an advocacy representative.

The inspectors received a report from the Peer Advocacy in Mental Health Representative.

The report stated residents liked the food, had privacy, as they had their own room, and felt the premises was nice, clean, comfortable and bright. A comment was received by an individual indicating that the resident liked the peacefulness of the approved centre.

Feedback from residents relating to staff reported in their opinion, “staff were very kind and hard working.” and “The nurses were good to the residents and the people who worked within the approved centre were wonderful.”

No comments were made in relation to areas in need of improvement.

# 6.0 Feedback Meeting

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

- Head of Service/RP Nominee
- General Manager
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Principal Social Worker
- Assistant Director of Nursing Compliance Support
- Occupational Therapist
- Acting Clinical Nurse Manager I

Apologies were provided by:

- Occupational Therapy Manager
- Principal Psychologist
- Consultant Psychiatrist
- Clinical Nurse Manager II
- Risk Advisor

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

# 7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

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

The approved centre used a minimum of two appropriate resident identifiers before administering medications, undertaking medical investigations, and providing other healthcare services. Identifiers included resident photograph, name, date of birth, and medical record number. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

**The approved centre was compliant with this regulation.**

## Regulation 5: Food and Nutrition

**COMPLIANT**

(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

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Menus ran for four weeks and were then rotated. Residents had at least two choices for meals.

A source of safe, fresh drinking water was available at all times in the approved centre. For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

**The approved centre was compliant with this regulation.**

## Regulation 6: Food Safety

**COMPLIANT**

(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

The approved centre provided suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation and serving of food. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs. Hygiene was maintained to support food safety requirements.

**The approved centre was compliant with this regulation.**

## Regulation 7: Clothing

**COMPLIANT**

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

Residents were provided with an adequate supply of male and female emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practises. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

**The approved centre was compliant with this regulation.**

## Regulation 8: Residents' Personal Property and Possessions

**COMPLIANT**

(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

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2021.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities, including safes provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated by their ICP and in accordance with the approved centre's policy.

**The approved centre was compliant with this regulation.**

## Regulation 9: Recreational Activities

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile. Recreational activities were led by nursing and health care assistant staff. Activities changed seasonally for specific times in the year, such as Christmas and Easter. Recreational activities taking place at the time of the inspection consisted of newspaper reading, walks in the garden, YouTube concerts, live music on a Tuesday, hand massage, Mass, news, Reeling in the Years, movie night, relaxation, nail painting and hair, ball games, watching sports events and listening to commentaries.

**The approved centre was compliant with this regulation.**

## Regulation 10: Religion

**COMPLIANT**

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

### INSPECTION FINDINGS

Residents' rights to practise religion were facilitated within the approved centre insofar as was practicable. Residents had access to Mass outside of the approved centre, in the foyer area every Tuesday. Diverse religious faiths were facilitated.

**The approved centre was compliant with this regulation.**

## Regulation 11: Visits

**COMPLIANT**

(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

The approved centre had written policies and procedures in relation to visits. The policy was last reviewed in July 2022. At the time of inspection, visiting times were flexible, appropriate, and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents could meet visitors in a private visiting area, called 'The Hive Room' or the garden area to receive visitors, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for visiting children.

**The approved centre was compliant with this regulation.**

## Regulation 12: Communication

**COMPLIANT**

(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

The approved centre had written policies and procedures in relation to communication. The policy was last reviewed in February 2021. Residents in the approved centre had access to postal mail, internet which included e-mail, and telephone, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Residents' also had access to the approved centre's electronic tablet for making video calls. No residents' communication coming in or going out was deemed necessary to be subject to examination by the approved centre at the time of the inspection.

**The approved centre was compliant with this regulation.**

## Regulation 13: Searches

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in June 2021, and included all requirements related to:

- 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.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

No searches took been conducted the approved centre since the last inspection, and compliance for this regulation was assessed on the basis of policy alone.

**The approved centre was compliant with this regulation.**

## 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

The approved centre had a written policy and procedures on care of the dying. This policy was last reviewed in October 2020.

The clinical file of one resident who passed away since the last inspection was examined on inspection. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. This was documented in the resident's individual care plan. Religious and cultural practices were respected. The privacy and dignity of the resident was protected, and the resident was given a single room within the approved centre during the provision of end of life care. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

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

**The approved centre was compliant with this regulation.**

## Regulation 15: Individual Care Plan

**COMPLIANT**

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

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT at least six-monthly, in consultation with the resident and their family representative. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

**The approved centre was compliant with this regulation.**

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

(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

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Social work and psychology provide in-reach service to the approved centre and a designated occupational therapist was based on the ward four days per week.

The therapy programme available to residents included groups undertaken every week, as follows: Reminiscence which was psychology led, music therapy where musicians from Waterford Healing Arts Trust attended the approved centre and co-facilitated with the occupational therapist, sports involving resident watching different sports in the Sun Room with occupational therapist (OT); art and gardening and imagination gym plus a movement a music group: all were OT led.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

**The approved centre was compliant with this regulation.**

## Regulation 18: Transfer of Residents

**COMPLIANT**

(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

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in August 2022. The clinical file of a resident who had been transferred in a non-emergency situation was examined. Full and complete written information for the resident was transferred when the resident was transferred, including a letter of referral that contained a list of current medications and a resident transfer form.

**The approved centre was compliant with this regulation.**

## Regulation 19: General Health

**COMPLIANT**

(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

The approved centre had a general health and medical emergency policy. The policy was last reviewed in April 2021.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans.

Three clinical files were examined in relation to the provision of general health services during the inspection process. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, medication review, nutritional status, and body mass-index, weight, and waist circumference.

Residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

**The approved centre was compliant with this regulation.**

## Regulation 20: Provision of Information to Residents

**COMPLIANT**

(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

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in March 2021.

The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

**The approved centre was compliant with this regulation.**

## Regulation 21: Privacy

**COMPLIANT**

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

### INSPECTION FINDINGS

Residents' dignity was appropriately respected at all times. The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms were fitted with blinds, curtains, or opaque glass. All residents had their own en-suite single bedroom. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make and take private phone calls.

**The approved centre was compliant with this regulation.**

## Regulation 22: Premises

**COMPLIANT**

(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

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards were minimised. Ligature points were minimised to the lowest practicable level, based on risk assessment. The approved centre was kept in good a state of repair externally and internally. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

**The approved centre was compliant with this regulation.**

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

**NON-COMPLIANT**

**Risk Rating** HIGH

(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

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in October 2021. The policy included:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for the administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident, and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible. 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.

Directions to crush medication were only accepted from the resident's medical practitioner. The approved centre did not have appropriate and suitable practices relating to the ordering and prescribing of crushed medications, as there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed. The approved centre did not have appropriate and suitable practices for the crushing of medications as the medical practitioner did not document within the MPAR that the specific medications were to be crushed.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

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

a) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the ordering and prescribing of crushed medications as there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, 23 (1).**
b) **The registered proprietor did not ensure that the approved centre had suitable practices for the crushing of medications as the medical practitioner did not document within the Medication Prescription Administration Record, that the specific medications were to be crushed, 23(1).**

## Regulation 24: Health and Safety

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in February 2023.

**The approved centre was compliant with this regulation.**

## Regulation 26: Staffing

**COMPLIANT**

(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

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2023, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The Approved Centre had three multi-disciplinary teams. This included psychiatry, nursing, occupational therapy, social work and psychology staff.

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing were sufficient to meet resident needs. All healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. All healthcare staff were trained in the Mental Health Act 2001.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre.

The following is a table of staff showing the numbers and percentages of staff trained in the four mandatory training topics:

**Staff Training Table**

| Profession | Basic Life Support | | Fire Safety | | Management Of Violence and Aggression | | Mental Health Act 2001 | |
|---|---|---|---|---|---|---|---|---|
| Nursing (17) | 17 | 100% | 17 | 100% | 17 | 100% | 17 | 100% |
| Consultant Psychiatrist (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Medical (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| Occupational Therapist (2) | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |
| Social Worker (2) | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |
| Psychologist (2) | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |

**The approved centre was compliant with this regulation.**

## Regulation 27: Maintenance of Records

**NON-COMPLIANT**

**Risk Rating** MODERATE

(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

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2021.

Resident records were not found to be kept in good order. Loose pages were present in three clinical files. Loose dividers were present in clinical files.

Not all records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. One file contained a loose page which was stored in the wrong section of the file.

Residents' records were developed and maintained in a logical sequence. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorised access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) **The registered proprietor did not ensure that the residents' clinical files were maintained in good order, as three clinical files contained loose pages, 27 (1).**
b) **The registered proprietor did not ensure that all records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. One file contained a loose page which was stored in the wrong section of the file, 27 (1).**

## Regulation 28: Register of Residents

**NON-COMPLIANT**

**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 electronic register of all residents admitted to the approved centre. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006: a discharge diagnosis was not completed for four individuals, 28 (2). The approved centre rectified this immediately and amended their process to allow on site senior staff to review and edit the register as required. At the time of inspection, off-site staff only had access to edit the register.

**The approved centre was non-compliant with this regulation as the registered proprietor did not ensure that the register included all the information specified in Schedule 1, namely a discharge diagnosis was not completed for four individuals, 28 (2).**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

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

All policies and procedures requiring a three-yearly review had been reviewed and updated as required.

**The approved centre was compliant with this regulation.**

## Regulation 30: Mental Health Tribunals

**COMPLIANT**

(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

The approved centre provided a large separate meeting room and staffing support to facilitate the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided resources and facilities to access the Mental Health Tribunals remotely if required.

**The approved centre was compliant with this regulation.**

## Regulation 31: Complaints Procedures

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in June 2021 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible and available for dealing with all complaints who was based in the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented. No non-minor complaints had been made since the previous inspection.

**The approved centre was compliant with this regulation.**

## Regulation 32: Risk Management Procedures

**NON-COMPLIANT**

**Risk Rating** HIGH

(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

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in April 2022. The risk management policy addressed all requirements. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff however not all risk management procedures actively reduced identified risks.

Not all clinical risks were adequately treated as MPAR's requiring crushed medication as an alternative administration method, recorded a blanket statement on the front page that all medications could be crushed. The related MPARs did not record which specific medications could be crushed as an appropriate preparation method. A risk noted the lack of dedicated pharmacy input was recorded on the risk register from May 2023.

All health and safety, and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

Individual risk assessments were completed prior to mechanical restraint and physical restraint, and in conjunction with medication requirements or administration, and resident transfer and discharge. Risk assessments were also completed during admission, to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives 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 and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

**The approved centre was non-compliant with this regulation as the clinical risk of crushing medication was not adequately treated, as kardex's did not specify which specific medication was to be crushed when prescribed. This meant the registered proprietor did not ensure that all aspects of the approved centre's risk management policy was implemented in practice, 31(1).**

## 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 at the reception area of the approved centre.

**The approved centre was compliant with this regulation.**

# 8.0 Inspection Findings – Rules

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

## Section 69: The Use of Mechanical Restraint

**COMPLIANT**

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

### INSPECTION FINDINGS

**Evidence of Implementation:** Three episodes of mechanical restraint were reviewed during the inspection process. Mechanical restraint was only used to address an identified clinical need and/or risk. Mechanical restraint was only used when less restrictive alternatives were deemed unsuitable. Each episode was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist on their behalf. A risk assessment of the safety and suitability of mechanical restraint was undertaken, and it specified the monitoring arrangements and frequency to be implemented during its use. The MDT developed a plan of care for each person restrained by mechanical means, including information on attempts to reduce or eliminate the use of restraint for that person.

Each clinical file contained a contemporaneous record that specified the following: that there was an enduring risk of harm to the self or others, that less restrictive alternatives were implemented without success, the type of mechanical restraint, the situation in which mechanical restraint was being applied, the duration of the restraint, the duration of the order, and the review date. The approved centre notified the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the correct format, and within the timeframes set by the Mental Health Commission.

**The approved centre was compliant with this rule.**

# 9.0 Inspection Findings – Mental Health Act 2001

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

## Part 4 Consent to Treatment

**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 file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment and that the patient was unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient. The form documented:

- The names of the medications prescribed.
- A 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 included the nature and purpose of the medications, as well as any supports provided to the patient in relation to the discussion and their decision making.

The effects of the medications, including risks and benefits were not specifically stated on the Form 17. Attempts were made to cover this with the patient but the patient was unable to respond, discuss or express their own view.

The form also included approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

# 10.0 Inspection Findings – Codes of Practice

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

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

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

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

## Use of Physical Restraint

**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 (PR). The policy had been reviewed annually and was dated December 2022. It addressed the following:

- The provision of information to the person which included information about the person's rights, presented in accessible language and format; information regarding who can initiate and who may carry out PR; information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of PR.
- Policies and procedures regarding staff training including the following:
  - Who will receive training based on the identified needs of persons who are restrained and staff
  - The areas to be addressed within the training programme, which included training in:
    The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques); alternatives to PR; trauma-informed care; cultural competence, human rights, including the legal principles of restrictive interventions; positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic, and the monitoring of the safety of the person during and after the PR.
    The identification of appropriately qualified person (s) to give the training.
  - The mandatory nature of training for those involved in PR.

The approved centre had a policy on the reduction of physical restraint. It addressed the following:

- Details of how the approved centre aimed to reduce, or where possible eliminate, the use of PR within the approved centre, including its use of positive behaviour support.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.

**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. All staff who participated or may participate in the use of physical restraint had received appropriate training in the use of physical restraint and in the related policies and procedures regarding staff training. All staff who participated or may participate in the use of physical restraint had received training in cultural competence, and in the positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic. A record of attendance at physical restraint training was maintained by the approved centre.

**Monitoring:** A multi-disciplinary review and oversight committee had been established to analyse every episode of physical restraint in detail, this committee had met at least quarterly.

**Evidence of Implementation:** The clinical files of three persons who had been physically restrained since the last inspection, were examined on inspection. PR was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy on physical restraint. The physical restraint order confirmed that there were no other less restrictive ways available to manage each person's presentation. The consultant psychiatrist (CP) or the duty consultant was notified as soon as was practicable and this was recorded in the clinical files. The RMP completed a medical examination of each of the persons (a physical examination) no later than two hours after the episodes of PR. The orders for PR lasted a maximum of 10 minutes.

The Clinical Practice Form (CPF) was signed by the CP within 24 hours. The persons were informed of reasons for, likely duration of, and circumstances leading to discontinuation of PR unless the information may have been prejudicial to the residents' mental health, well-being, or emotional condition.

In all episodes of physical restraint, as soon as was practicable, and as it was the person's wish in accordance with their individual care plan, the person's representative was informed of the person's restraint and a record of this communication was placed in the clinical file. The Mental Health Commission (MHC) was notified through the Comprehensive Information System (CIS) of the start time and date, and the end time and date of each episode of PR in the format specified by the MHC, within three days of the restraint.

A same sex staff member was present at all times during the episodes of PR. In the three episodes of physical restraint the person was continuously assessed throughout the use of restraint to ensure the person's safety and this was documented. In all three episodes of physical restraint the person's head and neck were supported where necessary. In all three episodes of physical restraint the person's airway and breathing were not compromised.

The person who lead the physical restraint ended it. The time, date, and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the person who was restrained followed two of the three episodes of PR. The person refused to engage in the de-brief in one episode of physical restraint. This debrief was person-centred and gave each person the opportunity to discuss the PR with members of the multi-disciplinary team (MDT) involved in the person's care and treatment as part of a structured debrief process.

The debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The debrief included a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future, such as preferences in relation to which restrictive intervention they would not like to be used. The person's individual care plan was updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief, and this was recorded in the clinical files.

The episodes of PR were recorded on the clinical practice forms located in the clinical file. The episodes of PR were reviewed by members of the MDT within five working days from the date of the restraint. The review covered everything required to be covered. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

**The approved centre was compliant with this code of practice.**

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had separate written policies in relation to admission, transfer, and discharge.

**Admission:** The admission policy, which was last reviewed in November 2022, included all of the policy-related criteria for this code of practice.

**Transfer:** The transfer policy, which was last reviewed in August 2022, included all of the policy-related criteria for this code of practice.

**Discharge:** The discharge policy, which was last reviewed in June 2021, included all of the policy-related criteria for this code of practice.

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

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

**Evidence of Implementation:**
**Admission:** The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history, family history, medical history, current and historic medication, where relevant, social and housing circumstances, current mental health state, risk assessment, full physical examination, and other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

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

**Discharge:** The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and risks, and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, and relevant members of the resident's multi-disciplinary team (MDT).

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and, informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: 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.**

## Appendix 1: Corrective and Preventative Action Plan

| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10004584** | | **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the ordering and prescribing of crushed medications as there was insufficient evidence of consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, 23 (1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Discussed need for access to pharmacist input for approved centre at QSEC Meeting in December 2023 (minutes attached section 15) escalated to Head of Service Risk Register and on Agenda for February 2024 EMT | This will continue to be monitored via HOS Office through QSEC and EMT Governance Structure and progress will be recorded on minutes | Yes | 30/06/2024 | HOS via QSEC and EMT Governance Structures |
| **Preventative Action** | Clinical Director has discussed funding options with the General Manager to explore options of the provision of private pharmacist consulting services to the approved centre | Through HOS and Governance Structures of QSEC and EMT and developments will be recorded on minutes | Yes | 30/06/2024 | Clinical Director and General Manager |
| **Reason ID : 10004585** | | **The registered proprietor did not ensure that the approved centre had suitable practices for the crushing of medications as the medical practitioner did not document within the MPAR, that the specific medications were to be crushed, 23(1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |

| | | | | | |
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| **Corrective Action** | The Clinical Director has communicated to prescribers for the approved centre that the documentation of the crushing of medications within the MPAR is a requirement and that the specific medications prescribed are to be crushed. | This will be monitored quarterly by the unit CNM and the Compliance Support ADON through the audit schedule for Reg.23 MPARS outcome will be discussed through QSPC and QSEC forums | Yes | 30/04/2024 | Clinical Director and Medical Practitioners |
| **Preventative Action** | The medical practitioner prescribing medication will document within the kardex specific instructions for each medication to be crushed. | This will be monitored quarterly by the unit CNM and the Compliance Support ADON through the audit schedule for Reg.23 MPARS outcome will be discussed through QSPC and QSEC forums | Yes | 30/04/2024 | Medical Practitioners |

| Regulation 27: Maintenance of Records | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10004580** | | **The registered proprietor did not ensure that the residents' clinical files were maintained in good order, as three clinical files contained loose pages, 27 (1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The loose pages in the three clinical files were secured and this non-compliance was rectified on the day of inspection in the presence of the inspector. | Audit completed on 02/08/2023 was compliant | Achieved | 02/08/2023 | Clinical Nurse Managers and all members of approved centre staff who have access to the health care records |
| **Preventative Action** | Administrative support has been put in place for the purposes of Reg.27 Maintenance of Records in the approved centres. | This will be monitored and audited regularly by unit ADON and ADON for Regulatory Compliance Support as per audit schedule for Aidans | Achieved | 31/01/2024 | General Manager has approved this action |
| **Reason ID : 10004581** | | **The registered proprietor did not ensure that all records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. One file contained a loose page which was stored in the wrong section of the file, 27 (1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Loose page that was incorrectly filed was rectified on the day in the presence of the inspector. | Measured by Reg.27 Audit of all HCRs on 02/08/2023 which achieved 100% compliance audit attached | Yes achieved | 26/07/2024 | CNM of Aidans |
| **Preventative Action** | A) Administrative Support sought and put in place for the | This will be monitored quarterly by the unit CNM and | Yes it is both achievable and realistic | 30/04/2024 | A)General Manager B)ADON for Aidans and ADON for Regulatory |

| | | | | | |
|---|---|---|---|---|---|
| | purposes of Regulation 27 Maintenance of Records<br>B)Regulation 27 Maintenance of Records monitored regularly by unit CNM during random checks and ADON for unit and Compliance Support ADON through audit schedule for 2024. (Quarterly audits), | the Compliance Support ADON through the audit schedule for Reg.23 MPARS outcome will be discussed through QSPC and QSEC forums | | | Compliance Support and unit CNM |

| Regulation 28: Register of Residents | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10004582** | | **The registered proprietor did not ensure that the register included all the information specified in Schedule 1, namely a discharge diagnosis was not completed for four individuals, 28 (2).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Rectified on the day on in the presence of the inspector, Register of Residents amended by the admin responsible for same to include the diagnosis on discharge for individuals identified | This was measured on the day of the inspection by the unit CNM and ADON for Regulatory Compliance Support who had registered rectified and observed the amended register in the presence of inspector. | Yes it is both realistic and has been achieved | 26/07/2023 | Unit CNM and Admin responsible for maintaining Register of Residents |
| **Preventative Action** | This will be monitored regularly by unit CNM and ADON for Regulatory Compliance spot checks and audited as part of 2024 audit schedule for Aidans to ensure compliance with Reg.28. Non compliances will be discussed at QPSC and QSEC forums. ADON for Regulatory Compliance support will an education session to unit staff | Measurable through SECH Reg.28 Audit Tool and regular spot checks | Yes this is both achievable and realistic | 31/03/2024 | Unit CNM and ADON for Regulatory Compliance Support |

| | | | | | |
|---|---|---|---|---|---|
| | and admin person responsible for register to reiterate the importance of accurate recording on the Register of Residents as per Reg. 28 | | | | |

| Regulation 32: Risk Management Procedures | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10004583** | | **The clinical risk of crushing medication was not adequately treated, as kardex's did not specify which specific medication was to be crushed when prescribed. This meant the registered proprietor did not ensure that all aspects of the approved centre's risk management policy was implemented in practice, 31(1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Discussed need for pharmacist input for approved centre at QSEC Meeting in December 2023 (minutes attached-section 15) escalated to Head of Service Risk Register and on Agenda for February 2024 EMT | This will continue to be monitored via HOS Office through QSEC and EMT Governance Structure | Achievable and Realistic | 30/06/2024 | General Manager and Head of Service (HOS) |
| **Preventative Action** | A) The medical practitioner prescribing medication will document within the kardex specific instructions for each medication to be crushed. This will be monitored regularly by the unit CNM and the Compliance Support ADON through the audit schedule for Reg.23 MPARS B) Clinical | A) Through SECH Audit Tool for Reg.23 MPARS B) Through HOS and Governance Structures of QSEC and EMT and developments will be recorded on minutes | Achievable and Realistic | 30/06/2024 | A) Medical Practitioner (B) Clinical Director and General Manager |

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|---|---|---|---|---|---|
| | Director has discussed funding options with the General Manager to explore options of the provision of private pharmacist consulting services to the approved centre | | | | |

## Appendix 2: Background to the inspection process

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

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

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

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

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

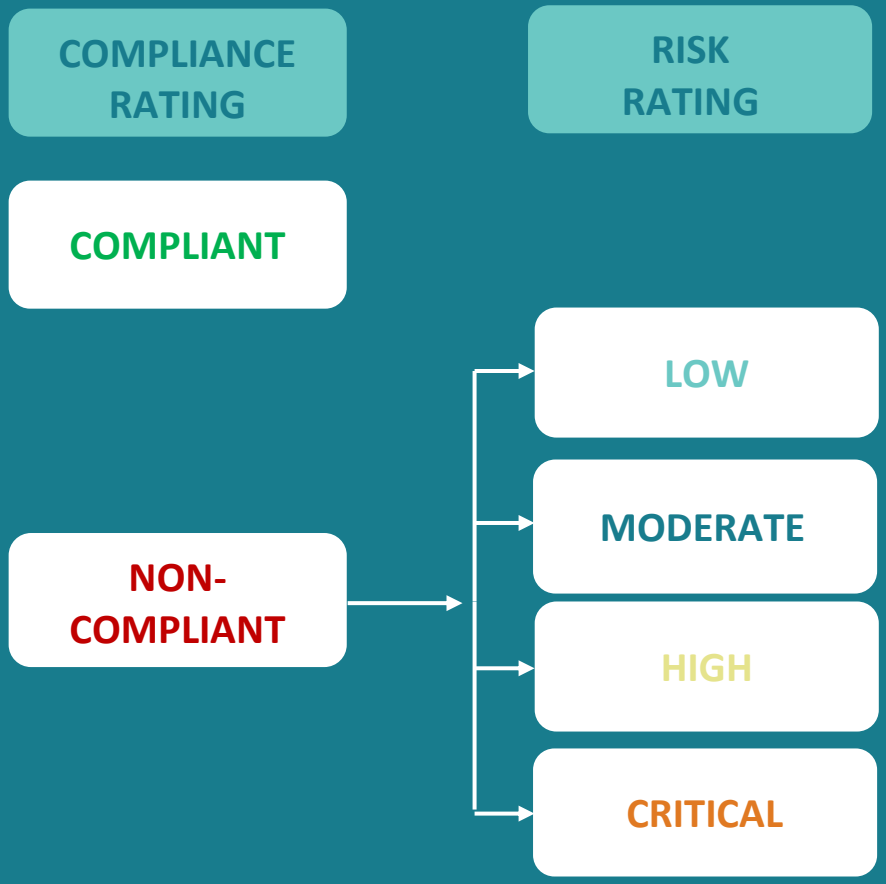
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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 and risk ratings, 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 AND RISK RATINGS

**The following ratings are assigned to areas inspected:**

**COMPLIANCE RATINGS are given for all areas inspected.**
**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.