Acute Psychiatric Unit, Ennis Hospital

ID Number: AC0022

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Psychiatric Unit
Ennis Hospital
Ennis
Co. Clare

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Mark Sparling, Head of Service - Mental Health, CHO 3

Inspection Team:
Dr David McGuinness, Lead Inspector
Dr Enda Dooley
Orla O'Neill
Mary Connellan

Inspection Date:
29 August – 1 September 2017

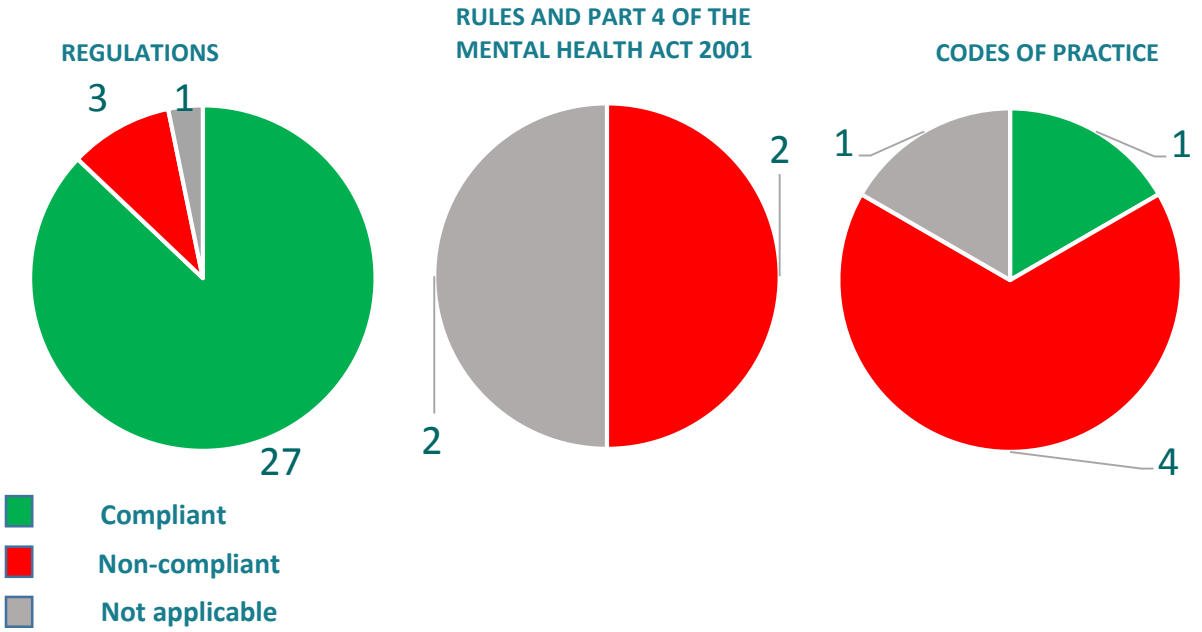
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
25 – 28 October 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
22 March 2018

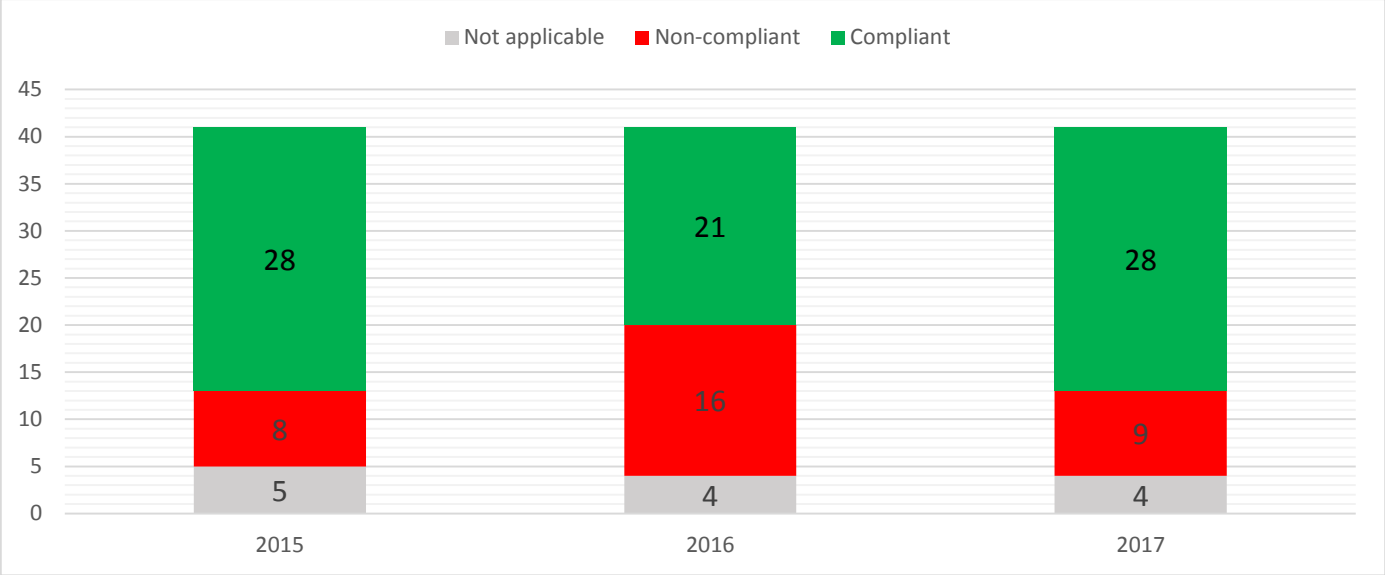
COMPLIANCE RATINGS 2017



RATINGS SUMMARY 2015 – 2017

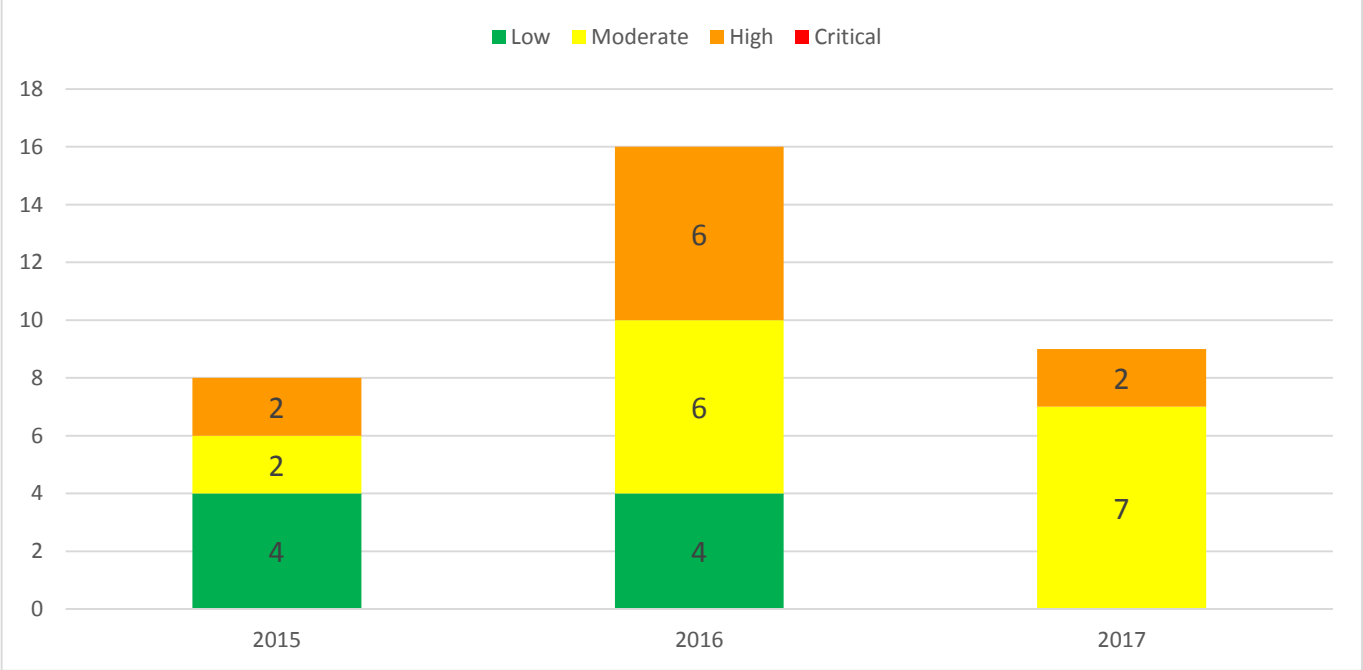
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017



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 2015 – 2017



Contents

1.0 Introduction to the Inspection Process

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

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

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

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

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

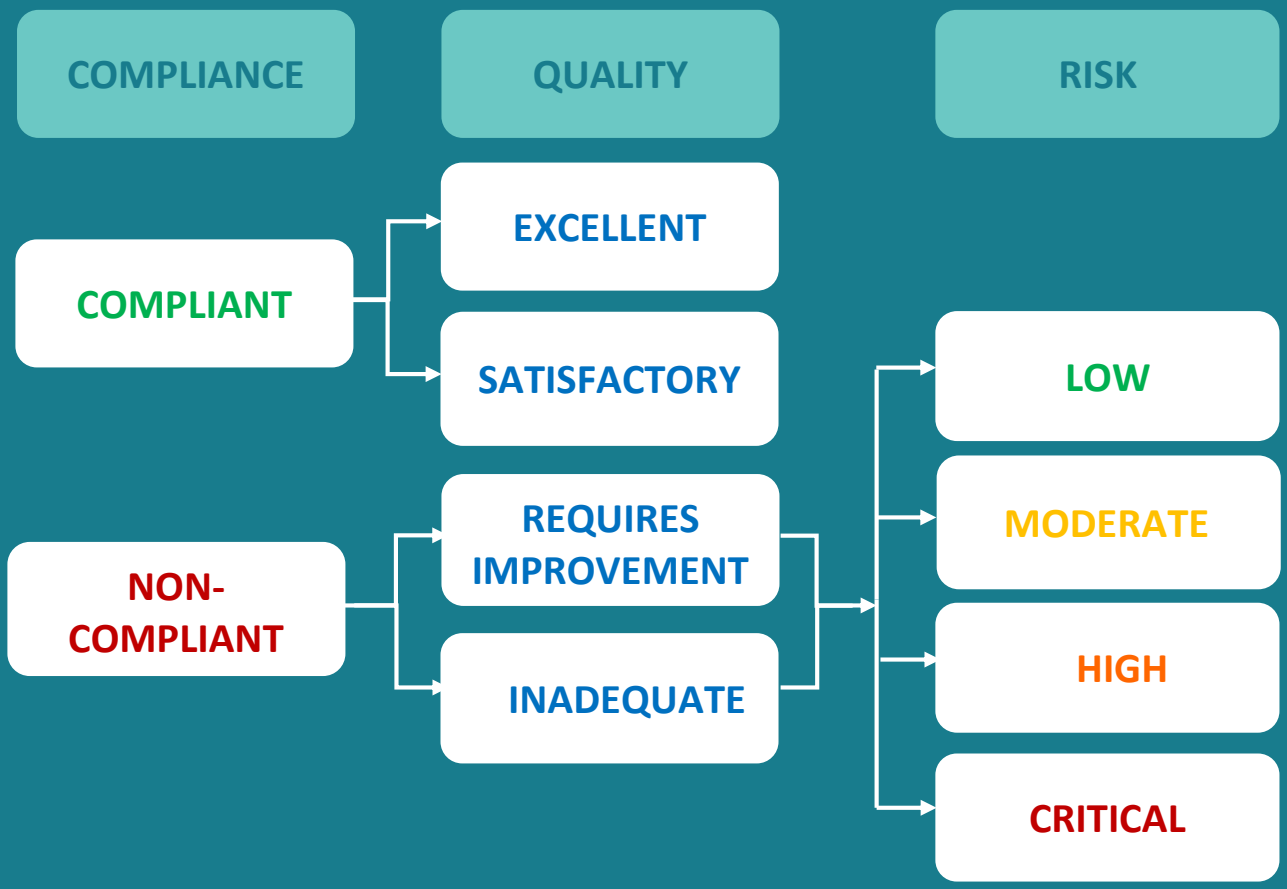
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE, QUALITY AND RISK RATINGS

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



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable 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.

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated *Judgement Support Framework*, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

Safety in the approved centre

There was a safety statement in place in relation to the health and safety of residents, staff, and visitors. The approved centre had a risk management policy in place and had adopted the HSE integrated risk management policy and supporting guideline and the safety incident management policy. A minimum of two resident identifiers appropriate to the resident group profile and residents' needs were used. Food safety audits were not periodically conducted but there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Ligature points were identified and rated. Remedial ligature free work had occurred, however not all ligature points were removed throughout the approved centre. Potential ligature points such as door handles, window handles and bed frames remained. There were safe processes in relation to the ordering prescribing, storage, and administration of medication. Not all health care professionals were up to date with required training in the areas of fire safety, Basic Life Support, the management of violence and aggression, and the Mental Health Act 2001.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan (ICP). The ICPs were discussed, agreed, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Each resident was offered a copy of their ICP, including any reviews. The therapeutic services and programmes were appropriate, evidence-based, reflective of good practice guidelines, and met the needs of the residents, as documented in the residents' ICPs. Residents' general health needs were monitored and assessed as indicated by their specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. Not all residents' records were in good order or developed or maintained in a logical sequence. Seclusion had been used in rare and exceptional circumstances to ensure the safety of the resident and others. The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment. It was also non-compliant with the code of practice in relation to physical restraint. When a child

was admitted, age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.

There were a number of delayed discharges from the approved centre – some due to homelessness and other risk issues. Consequently, in order to facilitate pending admissions, some residents had been requested to temporarily sleep overnight in a 24-hour residence. This was not in the best interests of the residents concerned.

AREAS REFERRED TO
Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27, Part 4 of the Mental Health Act 2001, Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Rule Governing the Use of ECT, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.

Respect for residents' privacy and dignity

All residents' clothing was clean and appropriate to their needs. Searches of residents were implemented with due regard to the residents' dignity, privacy, and gender. Each resident had a single bedroom with en suite facilities, and all bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. Rooms were generally not overlooked by public areas; if they did, the windows had opaque glass. Residents were facilitated to make private phone calls. CCTV was in use in the approved centre and residents were monitored solely for the purposes of ensuring their health, safety, and welfare. Cameras were incapable of recording or storing a resident's image on a tape, disc, or hard drive or in any other format. The seclusion room was furnished, maintained, and cleaned to ensure resident dignity, privacy, and safety. A toilet and washing facilities were available adjacent to the seclusion suite.

AREAS REFERRED TO
Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Responsiveness to residents' needs

The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome, nutritious, attractive, and varied food choices within the approved centre's menus. The approved centre provided access to recreational activities appropriate to the resident group profile and there was access to a gym room and outdoor garden areas, including gardening activities. There were facilities for residents' religious practices and residents had access to multi-faith chaplains. There were separate visitors' room and visiting areas and visiting times were flexible. Residents could use mail, fax, e-mail, telephone, and the Internet if they wished. They were provided with an information handbook at admission, and it included all necessary information. Diagnosis-specific information about medications was available.

The approved centre was adequately heated, and ventilated. It was clean, hygienic, and free from offensive odours. Sufficient spaces were provided for residents to move about, including outdoor spaces. It was kept in a good state of repair externally and internally. There was a robust complaints procedure in place and the

management of complaints processes was well publicised and accessible to residents and their representatives

AREAS REFERRED TO
Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Governance of the approved centre

The approved centre came within the governance structure of Clare, North Tipperary Mental Health Services. The Mid West Clare/North Tipperary Mental Health Services management team met with the Community Healthcare Organisation (CHO) 3 management team on a quarterly basis.

There was an organisational chart. The area lead of mental health engagement was a member of the CHO 3 management team. Minutes of management team meetings evidenced regular senior management meetings, which addressed issues such as the risk register, staffing, and infection control. The approved centre's operating policies and procedures were developed with input from some clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were not accompanied by signature sheets to indicate that they were communicated to all relevant staff. All operating policies and procedures required by the regulations were reviewed within three years.

AREAS REFERRED TO
Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Staff were trained in the *Safewards* intervention these included the use of de-escalation techniques and reduction of restrictive practices.

2. The shower and toilet facilities were refurbished in order to mitigate ligatures.

3. Two new Basic Life Support (BLS) instructors were trained which contributed to increasing the proportion of staff now trained in BLS.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Acute Psychiatric Unit (APU) was located on the ground floor of Ennis University Hospital, a short distance from the main hospital entrance. The approved centre was in its 10th and final phase of refurbishment, and the main entrance doorway and reception was blocked off as this area was under construction. As a result, entry was signalled through another entranceway at the rear of the approved centre. Significant refurbishment work had been undertaken since the last inspection, rectifying a number of issues pertaining to premises and privacy, which were identified at the time of the 2016 inspection.

The 39-bed APU was the acute psychiatric admissions unit for the adult population of Clare and North Tipperary. Thirty-four beds were allocated to general adult admissions and incorporated a high observation area and five beds were designated to psychiatry of later life (POLL). Three community mental health teams, a POLL team, and a rehabilitation and recovery team admitted residents from Clare. Two North Tipperary community mental health teams (Nenagh and Thurles) admitted residents also, and these residents were then under the care of an assigned consultant psychiatrist for the duration of their hospital stay in the APU.

The APU bed occupancy figures indicated that occupancy exceeded 100% for periods of time. There were a number of delayed discharges - some due to homelessness and other risk issues. Consequently, in order to facilitate pending admissions some residents had been requested on a temporary basis to sleep overnight in a 24-hour residence. This was not in the best interests of these residents. The approved centre previously had a condition attached to its registration, which required all residents to be accommodated in suitable sleeping accommodation to ensure their privacy and dignity were appropriately respected.

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

Resident Profile	
Number of registered beds	**39**
Total number of residents	**30**
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	2

4.2 Conditions to registration

Condition 1: To ensure adherence to *Regulation 21: Privacy* and *Regulation 22: Premises*, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.

Condition 2: To ensure adherence to *Regulation 26 (4): Staffing* the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

4.3 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.

4.4 Governance

The approved centre came within the governance structure of Clare, North Tipperary Mental Health Services. The inspection team was provided with the minutes of various minutes governing the APU, including the Mid West Clare/North Tipperary Mental Health Services Management Team, and the APU Operational Meeting. The Mid West Clare/North Tipperary Mental Health Services Management Team met with (CHO) 3 management team on a quarterly basis.

There was an organisational chart. The area lead of mental health engagement was a member of the CHO 3 management team. Minutes of management team meetings evidenced regular senior management meetings, which addressed issues such as the risk register, staffing, and infection control.

5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 25-27 October 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

Regulation/Rule/Act/Code	2017 Inspection Findings
Regulation 7: Clothing	Compliant
Regulation 13: Searches	Compliant
Regulation 18: Transfer of Residents	Compliant
Regulation 21: Privacy	Compliant
Regulation 22: Premises	Non-compliant
Regulation 26: Staffing	Non-compliant
Regulation 27: Maintenance of Records	Non-compliant
Regulation 28: Register of Residents	Compliant
Regulation 29: Operating Policies and Procedures	Compliant
Regulation 31: Complaints Procedures	Compliant
Rules Governing the Use of Seclusion	Non-compliant
Code of Practice Relating to Admission of Children under the Mental Health Act 2001	Non-compliant
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	Compliant
Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities	Non-compliant
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Non-compliant

5.2 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2016 and 2015:

Regulation/Rule/Act/Code	2015 **Compliance**	**2016 Compliance**	2017 Compliance
Regulation 22: Premises	✗	✗	✗
Regulation 26: Staffing	✗	✗	✗
Regulation 27: Maintenance of Records	✓	✗	✗
Rules Governing the Use of Seclusion	✓	✗	✗
Part 4 of the Mental Health Act 2001: Consent to Treatment	✓	✓	✗
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	✓	✗
Code of Practice Relating to Admission of Children under the Mental Health Act 2001	✗	✗	✗
Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	Not Applicable	✗	✗
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	✗	✗

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.

5.3 Areas of compliance rated Excellent on this inspection

No areas of compliance were rated excellent on this inspection.

6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

Nine service users completed the questionnaire, eight were aware of their care plan and seven knew who their key worker was. Some residents were complimentary of staff in the free text section of the questionnaire.

Two residents met privately with the inspectors. They outlined a variety of issues of personal or general concern, including limited access to recreation and activities during the weekend. Residents generally described positive engagement with staff. They perceived staff to be helpful and supportive.

The local IAN representative met with the inspector and outlined positive improvements with the approved centre issues.

7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with or received written response via email from the following individuals:

- Occupational Therapy Manager
- Principal Social Worker
- Principal Clinical Psychologist
- Assistant Director of Nursing

The medical, nursing, and occupational therapy heads of discipline had responsibility for mental health services alone. The head of discipline for social work also had responsibility for primary care as well as providing input into one multidisciplinary team within the approved centre.

Some heads of discipline outlined issues relating to both recruitment and retention of discipline-specific staff. All social workers were basic grade except for one senior practitioner. The involvement of discipline heads with the overall governance process relating to the approved centre also varied.

There were clear processes for escalating issues of concern to heads of discipline and to the area management team.

All heads of discipline had training in National Incident Management System, and two heads of discipline did not have training in health and safety.

8.0 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:

- Business Manager
- Senior Executive Officer
- Acting Executive Clinical Director/Clinical Director
- Principal Psychologist
- Social Worker (representing Principal Social Worker)
- Area Director of Nursing
- Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager (CNM) 3
- CNM 2x3

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. Clarification was sought from both the inspection team and representatives from the approved centre. These have been included in the relevant sections of the report.

9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy dated February 2016 on the identification of residents. The policy included requirements of the *Judgement Support Framework,* with the exception of the required use of two appropriate resident identifiers prior to the administration of medications, medical investigations, or other services.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on the identification of residents. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit was not undertaken to ensure there were appropriate resident identifiers on clinical files. A documented analysis had not been completed to identify opportunities for improving resident identification processes.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and residents' needs were used. Residents of the approved centre had the option of wearing wristbands with details of their identity. The approved centre used the name, address, and date of birth of each resident as identifiers.

The identifiers were detailed within each resident's clinical file and were checked by staff before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. There was a red sticker alert system in place to distinguish between same- and similar-named residents.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy on food and nutrition dated March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on food and nutrition. Relevant staff interviewed were able to articulate the processes relating to food and nutrition, as outlined in the policy.

Monitoring: A systematic review of menu plans was conducted by the dietician. The review ensured residents were provided with wholesome and nutritious food suitable to their needs. No documented analysis was completed to identify opportunities to enhance the food and nutrition processes.

Evidence of Implementation: Meals were prepared and cooked in the main kitchen of St. Joseph's Hospital and delivered to the approved centre. The approved centre's menus had been reviewed and approved by a dietician to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome, nutritious, attractive, and varied food choices within the approved centre's menus. Hot meals were served daily. Both hot and cold drinks were offered regularly, and residents had sufficient supplies of safe and fresh drinking water through water dispensers.

An evidence-based nutrition assessment tool was not routinely used but was implemented on an as required basis. A dietician or speech and language therapist was available through St. Joseph's Hospital, or the Medical Assessment Unit in Ennis General Hospital, or through the community intervention team on a referral basis. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in the resident individual care plan.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place on food safety. The policy included the requirements of the *Judgement Support Framework,* with the following exceptions:

- Food preparation, handling, storage, distribution and disposal controls.
- The management of catering and food safety equipment.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on food safety. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). Training was documented.

Monitoring: Food safety audits were not periodically conducted. Food temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored. Analysis was not completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on residents' clothing. Relevant staff interviewed were able to articulate the processes on residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. A record of residents wearing nightclothes during the day was kept and monitored.

Evidence of Implementation: Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans. Residents were provided with appropriate emergency personal clothing that took into account their preferences, dignity, bodily integrity, and religious and cultural practices. All residents' clothing was clean and appropriate to their needs.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre used the Mid West Mental Health Services Policy, dated February 2016, in relation to residents' personal property and possessions. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on residents' personal property and possessions. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored, and documented analysis was completed to identify opportunities to improve the processes for managing residents' personal property and possessions.

Evidence of Implementation: A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each resident's personal property and possessions. The property checklist was kept distinct from each resident's individual care plan. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plans.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated March 2016, in relation to the provision of recreational activities. The policy included requirements of the *Judgement Support Framework,* with the following exceptions:

- The process applied to risk assess residents for recreational activities, including outdoor activities.
- The facilities available for recreational activities, including identification of suitable locations for recreational activities within and external to the approved centre.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on recreational activities. Relevant staff interviewed were able to articulate the processes for residents' recreational activities, as set out in the policy.

Monitoring: There was a record of the occurrence of planned recreational activities, including a record of resident uptake and attendance. A documented analysis was completed to identify opportunities to improve the processes for recreational activity.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. A timetabled schedule of recreational activities was available to residents in poster format. Opportunities were provided for indoor and outdoor exercise and physical activity.

Residents had access to a gym room and outdoor garden areas, including gardening activities. Residents' unique perspectives on recreational activities informed recreational services. The activation nurse regularly solicited the views of residents and amended recreational provision accordingly. Documented records of attendance at recreational activities were maintained in group records or within each resident's clinical file, as appropriate.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place, dated March 2017, on the facilitation of religious practices. It also used the Health Services Intercultural Guide (2009). The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on religion. Relevant staff interviewed could articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support residents' religious practices had not been reviewed to ensure that it reflected the identified needs of the residents.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable, and there were facilities provided for residents' religious practices. Weekly mass was celebrated in the church in Ennis General Hospital. A minister of the Eucharist attended the approved centre each Sunday. Residents had access to multi-faith chaplains, and they were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services provided within the approved centre were respectful of the residents' religious beliefs and values.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

Processes: The approved centre had a written operational policy, dated February 2016, and protocols in place in relation to visits. The policy and protocols included the requirements of the *Judgement Support Framework,* with the following exceptions:

- The availability of appropriate adult locations for resident visits.
- The required visitor identification methods.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on visits. Relevant staff could articulate the processes for visits, as described in the policy.

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. A documented analysis of the processes relating to visits had not been completed.

Evidence of Implementation: Appropriate, reasonable, and flexible visiting times were publicly displayed throughout the approved centre. A separate visitors' room and visiting areas were available, unless there was an identified risk to the resident or others or a health and safety risk. The current temporary refurbishment works had reduced the availability of space, but this would be rectified once the works were completed. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times. The visiting room and facilities were suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy, dated April 2017, available in relation to communication. The policy included the requirements of the *Judgement Support Framework,* with the exception of the assessment of resident communication needs.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on communication. Relevant staff interviewed articulated the processes for communication, as set out in the policy.

Monitoring: Residents' communication needs and restrictions on communication were monitored on an ongoing basis and recorded in their clinical files. Analysis had not been undertaken to identify opportunities to improve the communication process.

Evidence of Implementation: Residents could use mail, fax, e-mail, telephone, and the Internet if they desired. The approved completed individual risk assessments, when necessary, in relation to any risks associated with residents' external communications; these were documented in each resident's individual care plan and in risk assessment documentation. Relevant senior staff only examined incoming and outgoing resident communication if there was cause to believe that the communication may result in harm to the resident or others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written Mid West Mental Health Services policy, dated February 2016, available in relation to the searching of a resident, his or her belongings, and the environment in which he or she was accommodated. The policy included requirements of the *Judgement Support Framework,* including

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she was accommodated.
- The process for the finding of illicit substances during a search.
- The consent requirements of a resident regarding searches and the process for implementing searches in the absence of consent.

The policy did not include the processes for communicating the approved centre's search policies and procedures to residents.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on searches. Relevant staff interviewed articulated the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. The search form had been updated on foot of last year's inspection findings.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents through the information leaflet. The approved centre did not conduct environmental searches.

There had been four searches of resident's personal property since the last inspection – documentation relating to two of these episodes were inspected. Risk had been assessed prior to the search, and resident consent was sought and documented. The resident was informed by those implementing the search of what was happening during the searches and why. A minimum of two clinical staff were in attendance at all times when the searches were being conducted. Policy requirements were implemented when illicit substances were found as a result of a search.

Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members who was conducting the search was the same gender as the resident. A written record of every search was available, separate from the respective resident clinical files. While these records documented the details of who was in attendance for the search, the specific reason for the search were only recorded in the individual files.

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre used the Mid West Mental Health Services policy, dated February 2016, in relation to care of the dying. The policy included requirements of the *Judgement Support Framework,* with one exception. While the policy addressed the notification of the approved centre of the death of a resident in a community residence, it did not detail the process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere (e.g. for general health care services and to other health care facilities such as a general hospital).

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy and protocols on care of the dying. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

Monitoring: No resident had received end of life care since the last inspection. Systems analysis was undertaken following the sudden death of a resident outside the approved centre.

Evidence of Implementation: Since the last inspection, there had been one sudden death of a resident who was on leave from the approved centre. Support was given to other residents and staff following the resident's death, and the Mental Health Commission was notified within 48 hours of the death occurring.

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

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: There was a policy on individual care plans (ICPs) dated March 2016. The policy covered all the requirements of the *Judgement Support Framework.*

Training and Education: Not all clinical staff had read and understood the policy on individual care planning. All clinical staff interviewed articulated the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members were trained in individual care planning.

Monitoring: Individual care plans were audited on a quarterly basis to assess compliance with the regulation. Analysis was completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: Each resident had an ICP, 15 of which were inspected. All ICPs were a composite set of documentation, which was stored within each resident's clinical file and was identifiable, uninterrupted, and not amalgamated with progress notes. Each resident had been assessed at admission by the admitting clinician and an initial ICP was established. The ICPs were then developed by the MDT following a comprehensive assessment, within seven days of admission. Evidence-based assessments were used.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. All ICPs identified appropriate goals, care and treatment, and interventions and specified the resources required to provide the care and treatment identified. The MDTs reviewed ICPs at least weekly, and these reviews were recorded in the ICPs. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances, and goals; this was documented.

All residents had access to their ICPs and were kept informed of any changes. Each resident was offered a copy of their ICP, including any reviews, and this was documented.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to therapeutic services and programmes, dated March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: There was evidence of ongoing monitoring of the range of therapeutic services and programmes provided to ensure that they met the assessed needs of residents. Documented analysis was not completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Information on therapeutic services and programmes provided was available to residents through a schedule of activities posted up in the approved centre. The therapeutic services and programmes provided were appropriate, evidence-based, reflective of good practice guidelines, and met the needs of the residents, as documented in the residents' individual care plans (ICPs).

All of the therapeutic programmes and services were provided by staff trained in accordance with their care delivery roles, and these programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Programmes included an exercise group, sleep hygiene, smoking cessation, healthy eating, and a yoga class. Psychological programmes included mindfulness, anxiety management, Wellness Recovery Action Plan group, self-esteem group, medication adherence, and art therapy.

Adequate resources and facilities were available. There was a full-time activation nurse and sector team occupational therapists, and social work staff provided one group each per week. There was no evidence of input from clinical psychology into the structured therapeutic programme. An art therapist provided three sessions per week.

Therapeutic services and programmes were provided in a separate dedicated room or in the occupational therapy department. There was an activities room, a gym, a group room, and a kitchen, as well as a garden where gardening was available as an activity.

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. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within each resident's clinical file.

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

Regulation 17: Children's Education

NOT APPLICABLE

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

INSPECTION FINDINGS

As the child admitted since the last inspection was not in the approved centre for longer than three days, the provision of educational services did not apply.

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated February 2016 in relation to the transfer of residents. The policy detailed the requirements of the *Judgement Support Framework,* with the following exceptions:

- The process for managing resident medications during transfer from the approved centre.
- The process for emergency transfers.
- The processes for ensuring the safety of the resident and staff during the resident transfer process.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on transfers. Relevant staff interviewed could articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was not maintained. No analysis was completed to identify opportunities to improve information provision during transfers.

Evidence of Implementation*:* The clinical file of one resident who had been transferred from the approved centre to a general hospital facility was inspected. This was a pre-planned transfer and not an emergency transfer. Documented consent of the resident to transfer was available.

Full and complete written information regarding the resident was transferred when he/she moved from the approved centre. Prior to transfer, the resident was assessed, which included an individual risk assessment relating to the transfer and an assessment of the resident's needs. This was documented and forwarded to the receiving facility in the form of a referral letter.

The clinical file recorded the documentation released to the receiving facility as part of the transfer, including the letter of referral, a list of current medications, the resident transfer form, and the required medication for the resident during the transfer process. The approved centre completed checks to ensure comprehensive resident records were transferred to the receiving facility.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: There were separate written policies in relation to general health (dated September 2015) and medical emergencies (dated June 2016). The policies included requirements of the *Judgement Support Framework,* with the exception of the following:

- The medical emergency policy did not include the management of emergency response equipment, including the resuscitation trolley and Automated External Defibrillator (AED).
- The general health policy did not detail the resource requirements for general health services, including equipment needs, the protection of resident privacy and dignity during general health assessments, or access to national screening programmes available for residents through the approved centre.

Training and Education: Not all clinical staff had signed a log to indicate that they had read the policies. All clinical staff interviewed were able to articulate the processes outlined in the medical emergencies policy and the general health policy.

Monitoring: Resident take-up of national screening programmes was recorded and monitored, where applicable. A systematic appraisal was not undertaken to ensure six-monthly reviews of general health needs took place. Analysis was not completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had an emergency trolley. Staff had access to a defibrillator, which was checked daily. 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' general health needs were monitored and assessed as indicated by their specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. Residents had access to appropriate national screening programmes. Information was not provided to residents regarding the available national screening programmes.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: There was a written operational policy, dated February 2016, and procedures available in relation to the provision of information to residents. The policy included the requirements of the *Judgement Support Framework,* with the exception of the process for identifying residents' preferred ways of giving and receiving information, and the methods for providing information to residents with specific communication needs.

Training and Education: Not all staff had signed a log to indicate that they had read the policy on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed, such as details on medication and housekeeping practices. Analysis had not been completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents were provided with an information handbook at admission, and it included all necessary information on housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; details of relevant advocacy and voluntary agencies; and residents' rights. Notices in public areas of the approved centre detailed residents' multi-disciplinary team (MDTs).

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. Medication information sheets, as well as verbal information, was provided to residents in a format that was aligned with the residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. Residents had access to interpretation and translation services, as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had an up-to-date policy, dated August 2017, in relation to privacy. The policy included the requirements of the *Judgement Support Framework,* with the exception of the approved centre's process to be applied where resident privacy and dignity were not respected by staff.

Training and Education: Not all staff had signed a log to indicate that they had read and understood the policy relating to resident privacy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: An annual review was not undertaken to monitor that the policy was being implemented because the policy was only in place a number of weeks. There was no documented analysis completed to identify the opportunities to improve the processes relating to residents' privacy and dignity.

Evidence of Implementation: Staff were dressed appropriately, appeared approachable, and were respectful of residents. Residents were dressed appropriately to ensure their privacy and dignity. All residents had their own single rooms. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Rooms were not overlooked by public areas. Residents were facilitated to make private phone calls, and had access to personal mobile phones.

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

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place, dated July 2017, in relation to the premises. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The approved centre had completed a hygiene audit, and a ligature audit. A documented analysis was completed to identify opportunities to improve the premises.

Evidence of Implementation: Accommodation for each resident in the approved centre assured their comfort and privacy and met their assessed needs. Each resident had a single bedroom with en-suite facilities. All bedrooms were appropriately sized to match residents' needs. There was a sufficient number of toilets and showers and appropriately sized communal rooms.

The approved centre was adequately heated, and ventilated. It was clean, hygienic, and free from offensive odours. Heating could be safely controlled in the residents' bedrooms in compliance with health and safety guidance and building regulations.

The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. 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, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.

Ligature points were identified and rated. Remedial ligature free work had occurred, however not all ligature points were removed throughout the approved centre. Potential ligature points such as door handles, window handles, and bed frames remained.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. Isolated areas of the approved centre were monitored.

The approved centre was non-compliant with this regulation as the presence of ligature points did not ensure that the premises were maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, 22(3).

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated June 2016, on the ordering, prescribing, storing and administration of medicines. The policy included requirements of the *Judgement Support Framework,* with the exception of the process for medication reconciliation, and the process to review resident medication.

Training and Education: Not all nursing, medical, and pharmacy staff had signed a log to indicate that they had read and understood the policy. Staff interviewed articulated the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and pharmacy staff were trained in reporting medication incidents or near misses, and documented evidence of training was provided.

Monitoring: Quarterly audits had been conducted on the Medication Prescription and Administration Records (MPARs). Incident reports were recorded for medication errors and near misses. Analysis was completed to identify opportunities for improvement of medication management processes.

Evidence of Implementation: Each resident had an MPAR. All MPARs inspected evidenced a record of appropriate medication management practices, including a record of the following: resident identifiers, medications administered, route of medication, dose of medication, and frequency of medication. The Medical Council Registration Number of the medical practitioner prescribing the medication was included in all cases. A record was kept when medication was refused by or withheld from a resident.

All medication was administered by a registered nurse or registered medical professional. Controlled drugs were checked by two staff members prior to administration. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. Medication arriving from the pharmacist was verified against the order by a nurse to ensure it was correct and was accompanied by appropriate directions for use. The medication trolley remained locked at all times and secured in a locked room. Medication was appropriately stored, and medication storage areas were clean and tidy.

There was no fridge temperature log in place at the time of the inspection. While the medication fridge was broken, medication requiring refrigeration was being stored in a domestic fridge that was locked elsewhere in the unit. A new fridge was ordered and was due to be delivered to the approved centre within a few days of this inspection. An inventory of medications was kept by the nursing staff, and unused or expired medication was returned to the pharmacy for disposal.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: There was a safety statement in place in relation to the health and safety of residents, staff, and visitors. The safety statement included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all staff had signed a log to indicate that they had read and understood the safety statement. Staff could articulate the processes relating to health and safety, as set out in the safety statement.

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place, dated March 2017, in relation to CCTV. The policy included the requirements of the *Judgement Support Framework,* with the exception of the process for the maintenance of CCTV cameras.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff interviewed articulated the processes relating to the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images were not checked regularly to ensure they were operating appropriately. A documented analysis was not completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: The Mental Health Commission had been informed about the approved centre's use of CCTV cameras. There were clear signs in prominent positions, which specified where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare.

CCTV cameras were incapable of recording or storing a resident's image on a tape, disc, or hard drive or in any other format. CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre did not have a local policy on staffing. Instead, it had a written statement adopting the generic HSE-National Recruitment Service policy. This policy set out the roles and responsibilities for the recruitment of staff and the appointment processes for all staff within the approved centre. The roles and responsibilities in relation to staff training processes were detailed in the policy. The approved centre's recruitment, selection and vetting processes were included in the policy.

The policy did not reference the following requirements of the *Judgement Support Framework:*

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

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

Monitoring: The number and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. No analysis was completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: The approved centre had an organisational chart, which identified the leadership and management structure and the lines of authority and accountability of the approved centre's staff. A planned and actual staff rota, showing the staff on duty at any one time in the approved centre, was maintained. The number and skill mix of staffing was sufficient to meet resident needs.

Staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment of staff. All staff, including permanent and contract staff, were vetted in accordance with the HSE's national recruitment policy. Staff had appropriate qualifications to do their job. An appropriately qualified staff member was on duty and in charge at all times.

There was no documentary evidence that the approved centre had a written staffing plan. Annual staff training plans were not completed for staff to identify required training and skills development in line with the assessed needs of the resident group.

While many staff had received training on Basic Life Support following the appointment of new instructors, there were gaps in training on other areas. Not all health care professionals were trained in the following:

- Fire safety.
- Basic Life Support.
- Professional Management of Aggression and Violence.
- The Mental Health Act 2001.

Manual handling, dementia care, care for residents with an intellectual disability, resident rights, and hand hygiene techniques training were completed by staff. At least one staff member was trained in Children First. All staff training was documented. Staff training logs were maintained.

Opportunities were made available to staff for further education. Where available, in-service training was completed by trained and competent individuals. Facilities and equipment were available for staff in-service education, and training.

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

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

Ward or Unit	Staff Grade	Day	Night
	CNM3	1	0
	CNM2	2	1
	RPN	7	5
	HCA	1	1
APU Ennis Hospital	Activation Nurse	1	
	Occupational Therapist	0	
	Social Worker	0	
	Psychologist	0	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (R0PN), Health Care Assistant (HCA)

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice. Not all health care professionals were up to date with required training in the areas of fire safety, Basic Life Support, and the management of violence and aggression, 26(4), or the Mental Health Act 2001, 26(4).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
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

Processes: The approved centre had a number of written operational policies in relation to the maintenance of records. The Mid West Mental Health Services policy was dated April 2017. The *Record Retention Periods Health Service Policy* was dated 2013. The approved centre also used the HSE's *Standards and Recommended Practices for Healthcare Records Management*. The documents, combined, included requirements of the *Judgement Support Framework,* with the following exceptions:

- Record review requirements.
- Residents' access to resident records.
- The process for making a retrospective entry in residents' records.
- The retention of inspection reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Resident records were not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis was not completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: Not all residents' records were in good order and some contained loose pages. All resident records were physically stored together. Records were maintained through the use of an identifier unique to the resident.

Not all resident records were developed or maintained in a logical sequence. One clinical file had gaps: a record was not kept of the medical review post-physical restraint, and a night report of the first day of admission was not recorded. This meant that this clinical file did not contain all the required information and had not been maintained in a manner that ensured completeness and accuracy.

Only authorised staff made entries into the resident records. Entries were factual and consistent, and each recorded the date and time using the 24-hour clock. Hand-written records were legible and written in black ink. Where an error was made, this was scored out with a single line and the correction written

alongside with the date, time, and staff member's initials. Two appropriate resident identifiers were not recorded on all documentation. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non-compliant with this regulation because the clinical file of one resident did not contain all of the required information and had not been maintained in a manner to ensure completeness and accuracy, 27(1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented and up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register included information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a statement adopting the HSE's National Framework for developing policies, procedures, protocols and guidelines, dated December 2016. The policy included the requirements of the *Judgement Support Framework,* with the following exceptions:

- The roles and responsibilities in relation to the development, management and review of operating policies and procedures.
- The process for making obsolete and retaining previous versions of operating policies and procedures.

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

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

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Logs were not signed by staff to indicate that policies and procedures had been communicated to all relevant staff. All operating policies and procedures required by the regulations were reviewed within three years. Obsolete versions of operating policies and procedures, which were retained, were not removed from possible access by staff.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy on Mental Health Tribunals dated September 2015. The policy included requirements of the *Judgement Support Framework,* with the following exceptions:

- The provision of information to the patient regarding the Mental Health Tribunals.
- The resources and facilities provided by the approved centre to support patients attending a Mental Health Tribunal, including the availability of staff to attend a tribunal, as necessary.

Training and Education: Not all relevant staff had read and understood the policy. Relevant staff were able to articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis was completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided adequate facilities and resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend a tribunal, as necessary.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated April 2016 in relation to the management of complaints. It also adopted the HSE's *Your Service, Your Say* complaints policy. The process for the management of 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, was detailed in the policy.

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

- The roles and responsibilities associated with the management of complaints within the approved centre, including a nominated person responsible to deal with all complaints.
- The documentation of complaints including the maintenance of a complaints log by the nominated person.

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

Monitoring: There was no evidence that an audit of the complaints log and related records was completed. Complaints data had not been analysed.

Evidence of Implementation: There were two nominated people responsible for dealing with all complaints who were available to the approved centre. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. The information was provided within the resident information booklet.

The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. 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.

All complaints (that were not minor complaints) were dealt with by the nominated person and recorded in the complaints log. A method for addressing minor complaints within the approved centre was provided. Minor complaints were documented. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. The complainant's satisfaction or dissatisfaction with the investigation findings was not documented.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy in place, dated August 2017. The approved centre also adopted the HSE's integrated risk management policy and supporting guideline, dated 2017, and the safety incident management policy. These documents were all up to date, comprehensive, and reviewed within the required three-year time frame. The policies included all of the requirements of the *Judgement Support Framework* and all of the policy-related regulatory requirements.

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

Monitoring: The risk register was audited on a quarterly basis by the risk advisor. All incidents in the approved centre were recorded and risk-rated. Analysis of incident reports was completed to identify opportunities for improvement of risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.

Clinical risks and corporate risks were identified, assessed, treated, monitored, and recorded in the risk register. While the recent bathroom refurbishment had minimised ligature points, other ligature risks such as door handles, window handles, and bed frames remained elsewhere.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A six-monthly summary of incidents was provided to the Mental Health Commission in line with the Code of Practice on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level.

There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures. The requirements for the protection of children and vulnerable adults in the approved centre were appropriate and implemented as required.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had up-to-date insurance. It indicated that the approved centre's insurance covered public liability, employers' 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

An up-to-date certificate of registration, with the conditions attached, was prominently displayed in the approved centre.

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

NOT APPLICABLE

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

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this rule was not applicable.

Section 69: The Use of Seclusion

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

Processes: The approved centre had a written policy, dated April 2017, on the use of seclusion. A separate policy and procedures were in place on training staff on seclusion. The policies, combined, included all requirements specified in the Rules Governing the Use of Seclusion.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy. The record of training was not maintained in an up-to-date manner, which meant there was no documented evidence that all staff involved in seclusion had completed up-to-date mandatory training.

Monitoring: There was a documented annual report on the use of seclusion.

Evidence of Implementation: There was a seclusion room in the approved centre, which was not used as a bedroom. Since the last inspection, padding had been installed on the walls of the seclusion room to mediate the risk of harm. The seclusion room was furnished, maintained, and cleaned to ensure resident dignity, privacy, and safety. A toilet and washing facilities were available adjacent to the seclusion suite.

The clinical file of one resident who had been secluded for less than two hours was inspected. Seclusion had been used in rare and exceptional circumstances to ensure the safety of the resident and others. The use of seclusion was based on a risk assessment and was initiated by a registered medical practitioner (RMP) or a registered nurse. The consultant psychiatrist was notified of the use of seclusion as soon as was practicable. Nurses observed the resident every 15 minutes, and the level of distress and behaviour of the resident was recorded. The resident was under continuous observation thereafter. The resident was informed of the ending of seclusion.

There was a CCTV camera in the seclusion room and CCTV viewing was restricted to designated personnel. The seclusion episode was reviewed by the multi-disciplinary team and documented in the relevant clinical file within two working days. The use of seclusion was recorded in the clinical file of the resident. A copy of the seclusion register was placed in the clinical file and was available to the inspector. It was documented that there was no known next of kin.

The approved centre was non-compliant with the Rules Governing the Use of Seclusion for the following reasons:

a) **Not all relevant staff had signed a log to indicate that they had read and understood the policy, 10.2(b).**
b) **There was no documented evidence that all staff involved in seclusion had completed up-to-date mandatory training, 11.2.**

Section 69: The Use of Mechanical Restraint

NOT APPLICABLE

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

As the approved centre did not use mechanical restraint, this rule was not applicable.

11.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

At the time of inspection Part 4 of the Mental Health Act 2001: Consent to Treatment applied to two patients only and the relevant clinical files were inspected. A Form 17, a second opinion by an independent consultant psychiatrist was in place and met the requirements of the Act. The second patient had provided written consent to specified medications on a pro forma document. Neither this written consent nor the relevant section of the clinical progress notes provided an adequate documentary record of the assessment of capacity. This meant that the requirements of the Act were not met.

The approved centre was non-compliant with this Part 4 of the Mental Health Act 2001: Consent to Treatment because the responsible consultant psychiatrist did not assess the patient's ability to consent to treatment, which includes an assessment of the patient's ability to understand the nature, purpose and likely effects of the proposed treatment, 56(a).

12.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: There was a written policy in place dated April 2017 in relation to the use of physical restraint. The policy was reviewed annually. There was a separate policy and procedures in relation to staff training on physical restraint. The policies included all of the guidance criteria of this code of practice.

Training and Education: Not all staff involved in physical restraint had signed a log to indicate that they had read and understood the policy. A record of attendance at training was maintained. Physical restraint was not used to ameliorate staff shortages.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: The clinical files of two residents who had been physically restrained were inspected. Physical restraint was used in rare and exceptional circumstances and in residents' best interests, when residents posed an immediate and threat of serious harm to themselves or others. The following was found on inspection:

- In one physical restraint episode, there was no evidence that the resident received a medical and physical examination by a registered medical practitioner no later than three hours after the start of physical restraint.
- In one physical restraint episode, there was no evidence that this resident received physical examination within three hours.
- In one episode of physical restraint, there was no evidence that the resident was informed of reasons, likely duration and circumstances which would lead to the discontinuation of physical restraint. There were no reasons documented as to why the resident was not informed.
- In one episode, the resident was not afforded the opportunity to discuss the physical restraint with a member of the multi-disciplinary team as soon as was practicable.

All uses of physical restraint were recorded clearly in the clinical practice form, and the completed form was placed in the clinical file of both residents.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **In one physical restraint episodes, there was no evidence that the resident received a physical examination by a registered medical practitioner no later than three hours after the start of physical restraint, 5.4.**
b) **In one episode of physical restraint, there was no evidence that the resident was informed of reasons, likely duration and circumstances which would lead to the discontinuation of physical restraint. There were no reasons documented as to why the resident was not informed, 5.8.**
c) **In one episode, the resident was not afforded the opportunity to discuss the episode of physical restraint with member of the multi-disciplinary team as soon as was practicable, 7.2.**
d) **Not all staff involved in physical restraint had signed a log to indicate that they had read and understood the policy, 9.2(b).**

Admission of Children

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had policies and protocols in place in relation to the admission of a child. There was a policy requiring each child to be individually risk assessed. Policy and procedures were in place with regard to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received up-to-date Children First training.

Monitoring: There was no evidence of an audit to monitor the admission of children processes.

Evidence of Implementation: The approved centre was an adult acute mental health service facility and not a child and adolescent approved centre. As a result, age-appropriate facilities and a programme of activities appropriate to age and ability were not available. The clinical file of one child who had been admitted to the approved centre since the last inspection was inspected.

Provisions were in place to ensure the safety of the child and to respond to the child's particular needs as a young person in an adult setting. The child did not have access to age-appropriate advocacy services, as there are none in non-private approved centre facilities. The child was given information on their rights.

In relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated and was arranged according to age and gender, including sleeping arrangements and bathroom areas. Staff were gender sensitive.

Appropriate visiting times for families, including children, were available. The Mental Health Commission was notified of the child admitted to the approved centre for adults within 72 hours using the appropriate notification form. Consent for treatment was obtained from at least one parent.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5(b).

Notification of Deaths and Incident Reporting

COMPLIANT

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: There was a risk management policy, which covered the notification of deaths and incident reporting to the Mental Health Commission. The policy included all elements of this code of practice.

Monitoring: Deaths and incidents were reviewed to identify and correct any problems as they arose and to improve quality.

Evidence of Implementation: The approved centre was compliant with Article 32 of the regulations. The National Incident Management System was used by the approved centre. A standardised incident report form was used and made available to inspectors. There had been two unexpected deaths in the approved centre since the last inspection, which were both notified to the Mental Health Commission within 48 hours.

The approved centre was compliant with this code of practice.

Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: There were policies and protocols for staff working with people with intellectual disabilities. The policies reflected person-centred treatment planning and presumption of capacity. Least restrictive interventions and staff roles and responsibilities were detailed in the policy. The approved centre did not have a policy on the management of problem behaviours or in relation to the training of staff in working with people with an intellectual disability.

Training and Education: The education and training provided did not support the principles and guidance material in the code of practice. Only two staff had been trained in working with people with an intellectual disability.

Monitoring: The policies were reviewed every three years.

Evidence of Implementation: One resident in the approved centre had been diagnosed with an intellectual disability. The resident had an individual care plan in place. A comprehensive assessment of the resident had taken place. A key worker was identified. The resident's preferred ways of giving and receiving information was established and documented.

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

a) **There was no policy on the management of problem behaviours, 5.3.**
b) **The education and training provided did not support the principles and guidance material in the code of practice, and only two staff had been trained in working with people with an intellectual disability, 6.1.**
c) **There was no policy on the training of staff in working with people with an intellectual disability and a mental illness, 6.2.**

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

NOT APPLICABLE

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

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.

Admission, Transfer and Discharge

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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: There were up-to-date policies on admission, transfer, and discharge in place. The policies included the relevant code of practice guidance criteria with the following exceptions:

- The discharge policy did not reference relapse prevention strategies, crisis management plans, a way of following up and managing missed appointments, a protocol for the discharge of people with an intellectual disability, and the process for supplying medication on discharge.
- The transfer policy did not reference the safety of residents and staff during resident transfer.

Training and Education: There was documented evidence that staff had read and understood the policies on admission and discharge. Not all staff had signed a log to indicate that they had read and understood the policy on transfer.

Monitoring: An audit of the implementation of and adherence to both the admission policy and the discharge policy did not take place.

Evidence of Implementation:

Admission: The approved centre complied with Regulation 7: Clothing, Regulation 8: Personal Property and Possessions, Regulation 15: Individual Care Plans, and Regulation 20: Provision of Information to Residents, which are associated with this code of practice. The approved centre did not comply with Regulation 27: Maintenance of Records. The clinical files of three residents were inspected against in relation to the admission process. The admission assessments were comprehensive. Admission was because of a mental illness or disorder. The residents were assigned a key worker. All assessments and examinations were documented in the clinical files.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The files of two residents who had been transferred were inspected. There were four episodes of transfer for the purpose of alleviating a bed shortage in the approved centre rather than in the resident's best interests. The second resident was transferred to receive medical treatment. The registered medical practitioner made the decision to transfer the residents and the decision to transfer was agreed with the receiving facilities. Resident assessments, including a risk assessment, were completed.

Discharge: The clinical files of three residents who had been discharged were reviewed. The decision to discharge the resident was made by a registered medical practitioner. A discharge plan was in place and documented as part of the residents' individual care plans. A comprehensive discharge summary was sent within 14 days to relevant personnel as required.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **The discharge policy did not include relapse prevention strategies, crisis management plans, a way of following up the discharged individuals, a process for managing missed appointments, or a protocol for the discharge of people with an intellectual disability and mental illness, 4.14.**
b) **The discharge policy did not include the process for supplying medication on discharge, 4.10.**
c) **The transfer policy did not reference the safety of residents and staff during resident transfer, 4.13.**
d) **There was no documented evidence that staff had read and understood the transfer policy, 9.1.**
e) **An audit of the implementation of and adherence to both the admission policy and the discharge policy did not take place, 4.19.**
f) **The approved centre did not comply with the Regulation 27: Maintenance of Records, 22.6.**
g) **There were four episodes of transfer for the purpose of alleviating a bed shortage in the approved centre rather than in the resident's best interests, 25.1.**

Appendix 1: Corrective and Preventative Action Plan Template – Acute Psychiatric Unit, Ennis Hospital

Regulation 22: Premises

Report reference: Page 40-41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*				
1. The presence of ligature points did not ensure that the premises were maintained with due regard to the specific needs of residents and patients and the safety and wellbeing of residents.	*Reoccurring since 2015* *Monitored as per Condition[3]*				

[1] Area of non-compliance reoccurring from 2016
[2] Area of non-compliance new in 2017
[3] To ensure adherence to *Regulation 21: Privacy* and *Regulation 22: Premises*, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.

Regulation 26: Staffing

Report reference: Page 47-49

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*				
2. Not all health care professionals were up to date with required training in the areas of Fire safety, Basic Life Support, the management of violence and aggression and the Mental Health Act 2001.	*Reoccurring since 2015* *Monitored as per Condition*[4]				

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

Regulation 27: Maintenance of Records

Report reference: Page 50

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
3. The clinical file of one resident did not contain all of the required information and had not been maintained in a manner to ensure completeness and accuracy.	*New*	Corrective Action(s): All clinical files have been put in good order Post-Holder(s) responsible:	All clinical files have been put in good order All Clinical Staff	Realistic	Complete
		Preventative Action(s): The files will be audited monthly along with the nurse metrics to ensure that they are adequately maintained. Post-Holder(s) responsible:	The files will be audited monthly along with the nurse metrics to ensure that they are adequately maintained. CNM2	Realistic	Monthly commencing in January 2018

Section 69: The Use of Seclusion

Report reference: Page 63-64

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
4. Not all relevant staff had signed a log to indicate that they had read and understood the policy.	*Reoccurring*	Corrective Action(s): All Heads of discipline have informed their staff to read and sign that they have read and understand the policy Post-Holder(s) responsible:	All Heads of discipline have informed their staff to read and sign that they have read and understand the policy. ADON/CNM3, Clinical Director	Achievable	Quarter 4 2017 See attached email from A/Clinical Director.
		Preventative Action(s): Six monthly Audit following rotation of staff Post-Holder(s) responsible:	Six monthly Audit following rotation of staff ADON/CNM3, Clinical Director	Achievable	January & July 2018
5. There was no documented evidence that all staff involved in seclusion had completed up-to-date mandatory training.	*New*	Corrective Action(s): All staff will have up-to-date mandatory training completed. Post-Holder(s) responsible:	All staff will have up-to-date mandatory training completed. Area Director of Nursing/ Practice Development Officer	Achievable	Quarter 1 2018
		Preventative Action(s): Training Log to be reviewed by Area Don / CD Post-Holder(s) responsible:	Training Log to be reviewed by Area Don / CD Clinical Director/ Area Director of Nursing/ Practice Development Officer	Achievable	Quarter 1 2018

Part 4: Consent to Treatment

Report reference: Page 67-68

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
6. The responsible consultant psychiatrist did not assess the patient's ability to consent to treatment, which includes an assessment of the patient's ability to understand the nature, purpose and likely effects of the proposed treatment.	*New*	Corrective Action(s): Full written record of specific medication has been provided and the nature and purpose of proposed treatment, likely adverse effects of treatment, risk and benefits and views expressed by the patient has been documented. Post-Holder(s) responsible:	Full written record of specific medication has been provided and the nature and purpose of proposed treatment, likely adverse effects of treatment, risk and benefits and views expressed by the patient has been documented. Mental Health Administrator/CD	Achievable	Completed See attached Patient Consent to continuation of Medication and Treatment form.
		Preventative Action(s): A review of adherence to the Patient Consent to continuation of medication form will be conducted on a quarterly basis. Post-Holder(s) responsible:	A review of adherence to the Patient Consent to continuation of medication form will be conducted on a quarterly basis. CNM 2 / Mental Health Administrator		End of Quarter 1, 2, 3, & 4 2018

Code of Practice: The Use of Physical Restraint

Report reference: Page 70-71

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
7. In one physical restraint episode, there was no evidence that the resident received a physical examination by a registered medical practitioner no later than three hours after the start of physical restraint.	*New*	Corrective Action(s): All aspects of relevant Code of Practice will be included in NCHD Induction. Post-Holder(s) responsible:	All aspects of relevant Code of Practice will be included in NCHD Induction. Clinical Director	Achievable	January 2018
		Preventative Action(s): Post-Holder(s) responsible:	Six monthly Audits following rotation of staff ADON/CNM3, Clinical Director	Achievable	January 2018
8. In one episode of physical restraint, there was no evidence that the resident was informed of reasons, likely duration and circumstances which would lead to the discontinuation of physical restraint. There were no reasons documented as to why the resident was not informed.	*New*	Corrective Action(s): The incident was reviewed by clinical staff and the Healthcare Record has been amended to reflect the review. The staff were made aware of the Code of Practice requirements. Post-Holder(s) responsible:	The incident was reviewed by clinical staff and the Healthcare Record has been amended to reflect the review. The staff were made aware of the Code of Practice requirements. ADON/CNM3/Clinical Director	Achievable	Complete
		Preventative Action(s): Post-Holder(s) responsible:	Code of Practice to be included in induction of all new staff. ADON/CNM3/Clinical Director	Achievable	January & July 2018

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
9. In one episode, the resident was not afforded the opportunity to discuss the episode of physical restraint with member of the multi-disciplinary team as soon as was practicable.	*New*	Corrective Action(s): The incident was reviewed by clinical staff and the Healthcare Record has been amended to reflect the review. The staff were made aware of the Code of Practice requirements. Post-Holder(s) responsible:-	The incident was reviewed by clinical staff and the Healthcare Record has been amended to reflect the review. The staff were made aware of the Code of Practice requirements. ADON/CNM3/Clinical Director	Achievable	Complete
		Preventative Action(s): The incident was reviewed by clinical staff and the Healthcare Record has been amended to reflect the review. The staff were made aware of the Code of Practice requirements. Post-Holder(s) responsible:	The incident was reviewed by clinical staff and the Healthcare Record has been amended to reflect the review. The staff were made aware of the Code of Practice requirements. ADON/CNM3/Clinical Director	Achievable	January & July 2018
10. Not all staff involved in physical restraint had signed a log to indicate that they had read and understood the policy.	*New*	Corrective Action(s): Post-Holder(s) responsible:	All Heads of disciplines have informed their staff to read and sign that they have read and understand the policy. ADON/CNM3, Clinical Director	Achievable	Complete See attached email from A/Clinical Director.
		Preventative Action(s): Post-Holder(s) responsible:	Six monthly Audit following rotation of staff ADON/CNM3, Clinical Director	Achievable	January & July 2018

Code of Practice: Admission of Children

Report reference: Page 72

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
11. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.	*Reoccurring*	Corrective Action(s): Ensure period of Admission is as brief as possible In the event of a child being admitted an individual programme of activities is developed tailored to their needs as part of the child's care plan. Headspace Toolkit MHC Booklet is made available should a child admission occur. CAMHS key worker will liaise with the unit staff, and family/carers as appropriate to ensure all possible options are considered. Post-Holder(s) responsible: CAMHS ADON & Unit ADON	Review of clinical file. Review of ICP and Nursing Care Plan by Clinical Team.	This is an Adult facility and the programmes provided are not often suited to the needs of young persons. Admission periods are usually quite short and a programme may not be in place immediately on admission but where the duration of stay is likely to be extended a programme of education will be put in place to cater for the needs of the individual child/adolescent.	Complete

Code of Practice: Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities

Report reference: Page 74

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
12. There was no policy on the management of problem behaviours. 13. There was no policy on the training of staff in working with people with an intellectual disability and a mental illness.	Reoccurring	Corrective Action(s): Policy has been reviewed and requirements added to Policy Post-Holder(s) responsible:	Policy has been reviewed and requirements added to Policy. Area DON/ ECD/HOS	Achievable	Complete See attached Policy
		Preventative Action(s): Policy has been reviewed and requirements added to Policy Post-Holder(s) responsible:	Policy has been reviewed and requirements added to Policy Area DON/ ECD	Achievable	Complete
14. The education and training provided did not support the principles and guidance material in the code of practice, and only two staff had been trained in working with people with an intellectual disability.	New	Corrective Action(s): All clinical staff including MDT to undertake HseLand Training on Communication with Persons with Intellectual Disability and same recorded on training log. Post-Holder(s) responsible:	All clinical staff including MDT to undertake HseLand Training on Communication with Persons with Intellectual Disability and same recorded on training log. HOD, Nursing, Social Work, Occupational Therapy, Psychology, Medical	Achievable	Quarter 1 2018
		Preventative Action(s): All clinical staff including MDT to undertake HseLand Training on Communication with Persons with Intellectual Disability and same recorded on training log. Post-Holder(s) responsible:	All clinical staff including MDT to undertake HseLand Training on Communication with Persons with Intellectual Disability and same recorded on training log. HOD, Nursing, Social Work, Occupational Therapy, Psychology, Medical	Achievable	Quarter 1 2018

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 76-77

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
15. The discharge policy did not include: relapse prevention strategies, crisis management plans, a way of following up with the discharged individuals, a process for managing missed appointments, or a protocol for the discharge of people with an intellectual disability and mental illness. 16. The discharge policy did not include the process for supplying medication on discharge. 17. The transfer policy did not reference the safety of residents and staff during resident transfer.	Reoccurring	Corrective Action(s): Policy has been reviewed and requirements added to Policy. Post-Holder(s) responsible:	Policy has been reviewed and requirements added to Policy. Area DON/ ECD/HOS	Achievable	Complete Attached revised Policy
		Preventative Action(s): Policy has been reviewed and requirements added to Policy. Post-Holder(s) responsible:	Policy has been reviewed and requirements added to Policy. Area DON/ ECD/HOS	Achievable	Complete See attached revised policy
18. There was no documented evidence that staff had read and understood the transfer policy.	New	Corrective Action(s): All Heads of disciplines have informed their staff to read and sign that they have read and understand the policy. Post-Holder(s) responsible:	All Heads of disciplines have informed their staff to read and sign that they have read and understand the policy. ADON/CNM3, Clinical Director	Achievable	Quarter 1 2018 See attached email from A/Clinical Director.
		Preventative Action(s): Six monthly Audit following rotation of staff Post-Holder(s) responsible:	Six monthly Audit following rotation of staff ADON/CNM3, Clinical Director	Achievable	January & July 2018

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
19. An audit of the implementation of and adherence to both the admission policy and the discharge policy did not take place.	New	Corrective Action(s): Audit of Code of Practice: Admission, Transfer and Discharge to be carried out. Post-Holder(s) responsible:	Audit of Code of Practice: Admission, Transfer and Discharge to be carried out. CNM3/CNM2	Achievable	January & July 2018
		Preventative Action(s): Audit Schedule will be implemented which will include Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge. Post-Holder(s) responsible:	Audit Schedule will be implemented which will include Six-Monthly audit of Code of Practice: Admission, Transfer and Discharge. CNM3/CNM2	Achievable	January & July 2018
20. There were four episodes of transfer for the purpose of alleviating a bed shortage in the approved centre rather than in the resident's best interests.	New	Corrective Action(s): All transfers are now conducted in accordance with Code of Practice. Post-Holder(s) responsible:	All transfers are now conducted in accordance with Code of Practice. CD & Consultants	Achievable	Ongoing through 2018
		Preventative Action(s): All transfers are now conducted in accordance with Code of Practice Post-Holder(s) responsible:	All transfers are now conducted in accordance with Code of Practice CD & Consultants	Achievable	Ongoing through 2018