# Cois Dalua

**ID Number:** AC0104

## 2018 Approved Centre Inspection Report (Mental Health Act 2001)

Cois Dalua
Meelin
Knockduff Upper
Newmarket
Co. Cork

**Approved Centre Type:**
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Forensic Mental Health Care
Mental Health Care for People with Intellectual Disability

**Most Recent Registration Date:**
1 June 2018

**Conditions Attached:**
None

**Registered Proprietor:**
Nua Healthcare Services

**Registered Proprietor Nominee:**
Mr Chris Hindle, Chief Executive Officer

**Inspection Team:**
Karen McCrohan, Lead Inspector
Martin Mc Menamin
Mary Connellan
Dr Susan Finnerty, MCRN009711

**Inspection Date:**
2 – 4 October 2018

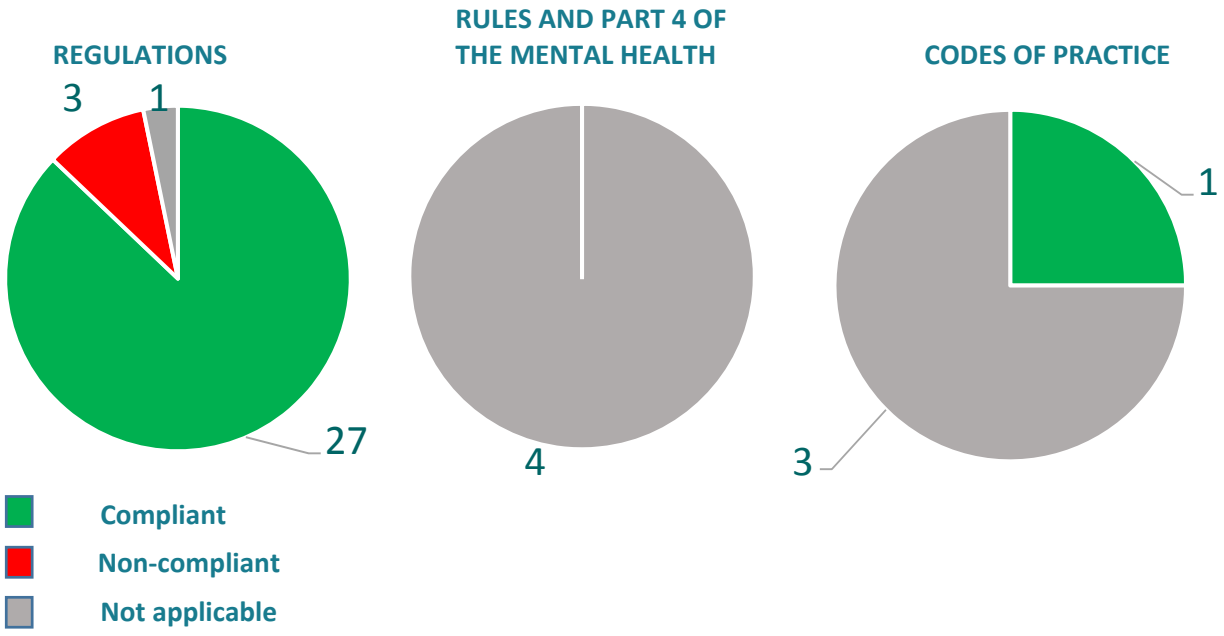
**Inspection Type:**
Unannounced Annual Inspection

**Previous Inspection Date:**
N/a

**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Date of Publication:**
<<** – ** Month 2018>>

## 2018 COMPLIANCE RATINGS



# RATINGS SUMMARY 2016 – 2018

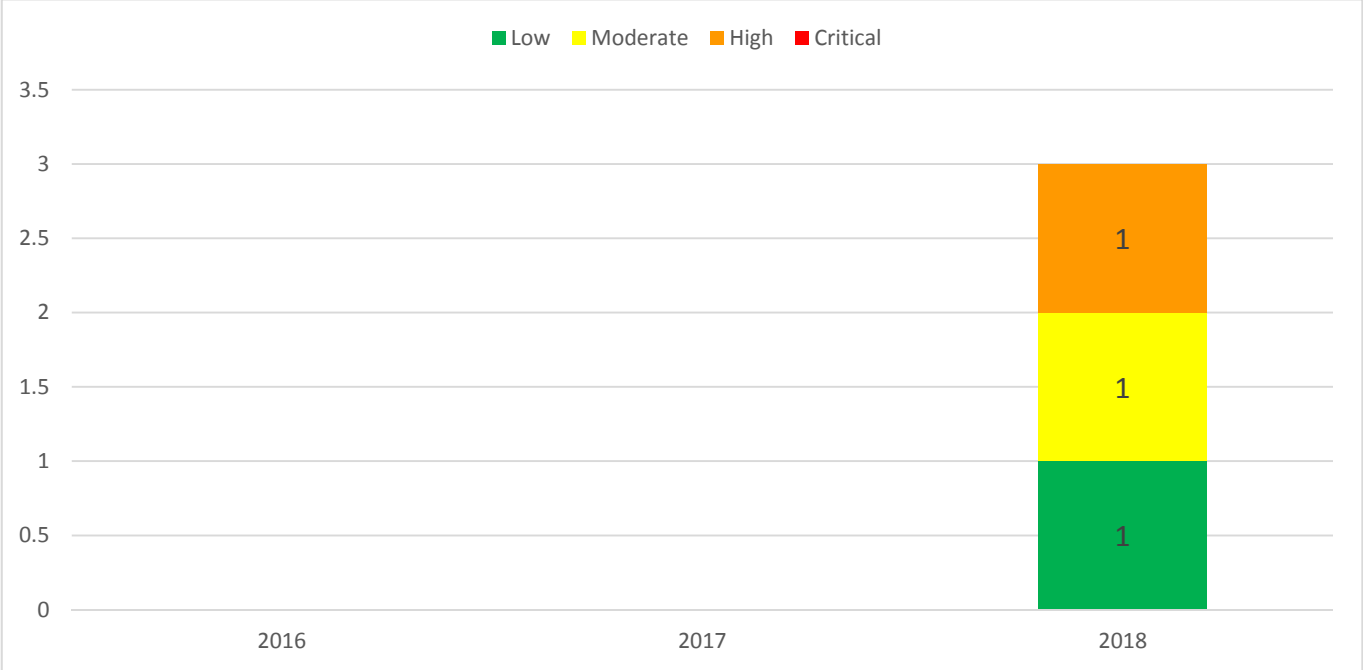
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

## Chart 1 – Comparison of overall compliance ratings 2016 – 2018


***Please note:*** **The approved centre opened in June 2018.**

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

## Chart 2 – Comparison of overall risk ratings 2016 – 2018




***Please note:*** **The approved centre opened in June 2018.**

# 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.

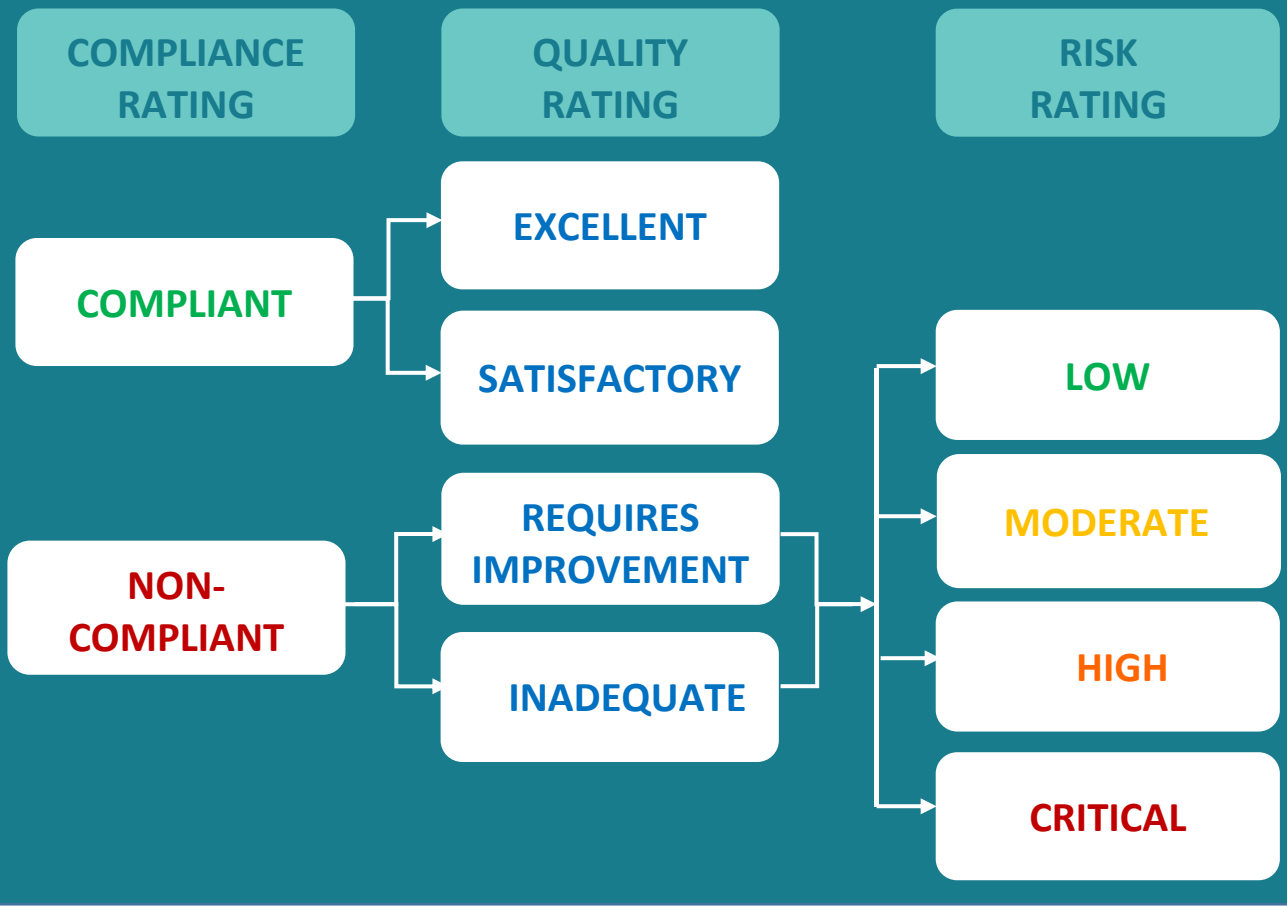
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, 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 generally given for all regulations, except for 28, 33 and 34.**
**RISK RATINGS are given for any area that is deemed non-compliant.**




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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.

# 2.0 Inspector of Mental Health Services – Review 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.*

## In brief

Cois Dalua was a new Specialist Rehabilitation Unit which opened in 2018 and was operated by Nua Healthcare, a for-profit organisation. Nua Healthcare had a service-level agreement with the HSE to provide specialist inpatient rehabilitation care for service users from all over Ireland. It was located in Meelin, eight kilometres from Newmarket, in County Cork, a relatively isolated area. Cois Dalua could accommodate eight residents, over the age of eighteen years, at full capacity and had four residents at the time of inspection. The accommodation comprised of four single en suite bedrooms and four self-contained apartments.

The approved centre was compliant with 90% of regulations and codes of practice. Six compliances with regulations were rated as excellent.

## Safety in the approved centre

Food safety audits were carried out regularly and kitchen areas were clean. Ordering, prescribing, storage and administration of medication was carried out in a safe manner. All staff were trained in fire safety, Basic Life Support, prevention and management of aggression and violence and the Mental Health Act 2001. There had been no recorded patient-related incidents at the time of the inspection. While structural risks, including ligature points, remained evident within the approved centre at the time of the inspection, these were effectively mitigated.

## Appropriate care and treatment of residents

Each resident had an individual care plan (ICP). One resident did not have an initial care plan completed. All residents received a comprehensive evidenced-based assessment. The ICP was developed and reviewed with the participation of the resident. None of the ICPs identified the resident's assessed needs, appropriate goals, or the care and treatment required to meet the goals identified. All residents were offered a copy of their ICP, including any reviews.

There was evidenced-based therapeutic services and programmes available for residents with space to provide these programmes, delivered by appropriately trained staff. Residents had access to primary care physicians and any other medical treatment necessary.

Clinical files were kept in good order. Two appropriate resident identifiers were not recorded on all documentation; documents containing no resident identifier were evident within the clinical files inspected.

## Respect for residents' privacy, dignity and autonomy

There were four single rooms and four apartments in the approved centre. The layout of the residence allowed residents privacy and personal space. No area was overlooked by the public. The residents wore their own clothes and retained control over their own property. Residents could meet their visitors in private and communication was not restricted. The entrance door to Cois Dalua was locked at the time of the inspection, and access was by requested access or PIN code keypad.

There were eight internal CCTV cameras, which were used solely to ensure the health and safety, and welfare of residents. CCTV cameras were incapable of recording or storing a resident's image and were only transmitted to a monitor that was viewed solely by the health professional responsible for the resident.

Seclusion was not used in the approved centre and physical restraint had not been used since the approved centre opened in 2018.

## Responsiveness to residents' needs

There was a wide range of recreational programmes that could be accessed during the week and at weekends. Information provided to residents was not adequate. The information booklet did not contain information about visiting times and visiting arrangements or relevant advocacy and voluntary agencies details. In addition, information on indications for use of all medications to be administered to the resident, including any possible side-effects, was not provided in written form. The approved centre was clean and well maintained.

## Governance of the approved centre

There was evidence of effective governance systems within Nua Healthcare's overall governance structure. The approved centre's local governance matrix was consolidated into a weekly national governance matrix, which enabled effective monitoring by Nua Healthcare's Senior Management and Executive Management Team. There was evidence of a weekly governance call, a fortnightly Quality and Safety Committee meeting, and a monthly Clinical Governance Committee meeting.

The approved centre's staff reported that Nua Healthcare implemented processes to monitor service quality and staff performance. Nua Healthcare's Quality and Audit Framework and auditing system (Viclarity) were identified as systems used to support quality improvement.

The approved centre did not have a local risk register at the time of the inspection. 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.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were recorded on Nua Healthcare's incident reporting system (AIRS) but these were not risk-rated in a standardised format.

# 3.0 Quality Initiatives

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

1. Implementation of Nua Healthcare's Quality and Audit Framework, in conjunction with their auditing system (Viclarity).

2. Establishment of weekly community meetings to facilitate meaningful resident engagement.

3. Introduction of multi-disciplinary in-service training and education.

# 4.0 Overview of the Approved Centre

## 4.1 Description of approved centre

Cois Dalua was a new Specialist Rehabilitation Unit, operated by Nua Healthcare. The approved centre was a newly renovated detached bungalow. It was located in a small village called Meelin, eight kilometres from Newmarket, in County Cork. Cois Dalua could accommodate eight residents, over the age of eighteen years, at full capacity. The accommodation comprised of four single en suite bedrooms and four self-contained apartments. The approved centre's communal areas included a dining room, two open-plan living areas, two kitchenettes, and a quiet room, in addition to a small, enclosed courtyard and well-designed sensory garden.

A Wellness Recovery Action Planning model of care was provided by a dedicated rehabilitative multi-disciplinary team, which consisted of a Clinical Director, Clinical Psychologist, Occupational Therapist, Registered Psychiatric Nurses, and Healthcare Assistants.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | **8** |
| **Total number of residents** | **4** |
| Number of detained patients | 1 |
| Number of wards of court | 0 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 0 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 4.2 Conditions to registration

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

## 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

There was evidence of effective governance systems within Nua Healthcare's overall governance structure. The approved centre's local governance matrix was consolidated into a weekly national governance matrix, which enabled effective monitoring by Nua Healthcare's Senior Management and Executive Management Team. There was evidence of a weekly governance call, a fortnightly Quality and Safety Committee meeting, and a monthly Clinical Governance Committee meeting. The inspection team were provided with all requested meeting minutes, which evidenced discussions regarding risk management, policy development,

service audits, and quality initiatives. Additionally, a local Quality and Safety committee had been established at Cois Dalua.

The Mental Health Commission's Governance questionnaire was completed by the approved centre's Clinical Director, Clinical Psychologist, Occupational Therapist, Clinical Nurse Manager 3, and Clinical Nurse Manager 2. This indicated that there was clear reporting systems for all disciplines. The approved centre's staff also reported that Nua Healthcare implemented processes to monitor service quality and staff performance. Nua Healthcare's Quality and Audit Framework and auditing system (Viclarity) were identified as systems used to support quality improvement.

## 4.5 Use of restrictive practices

The entrance door to Cois Dalua was locked, at the time of the inspection, and access was by requested access or PIN code keypad. This restriction was implemented in consideration of the residents' assessed clinical needs and to ensure their safety.

# 5.0 Compliance

## 5.1 Non-compliant areas on this inspection

**The approved centre opened in June 2018 and therefore there were no previous years' inspections.**

Non-compliant (X) areas on this inspection are detailed below.

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2018 | |
|---|---|---|
| Regulation 15: Individual Care Plan | X | High |
| Regulation 20: Provision of Information to Residents | X | Moderate |
| Regulation 27: Maintenance of Records | X | Low |

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

## 5.2 Areas of compliance rated "excellent" on this inspection

| Regulation |
|---|
| Regulation 6: Food Safety |
| Regulation 7: Clothing |
| Regulation 8: Residents' Personal Property and Possessions |
| Regulation 9: Recreational Activities |
| Regulation 10: Religion |
| Regulation 19: General Health |

## 5.3 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre did not admit children, this regulation was not applicable. |
| Rules Governing the Use of Electro-Convulsive Therapy | As the approved centre did not provide an ECT service, this rule was not applicable. |
| Rules Governing the Use of Seclusion | As the approved centre did not use seclusion, this rule was not applicable. |
| Rules Governing the Use of Mechanical Means of Bodily Restraint | As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable. |
| Part 4 of the Mental Health Act 2001: Consent to Treatment | As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable. |

| | |
|---|---|
| Code of Practice on the Use of Physical Restraint in Approved Centres | As the approved centre did not use physical restraint, this code of practice was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre did not admit children, this code of practice was not applicable. |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | As the approved centre did not provide an ECT service, this code of practice was not applicable. |

# 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 inspection team interacted informally with the residents during the course of the inspection at Cois Dalua. However, none of the residents requested to speak privately with the inspectors and no service user experience questionnaires were completed.

# 7.0 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:

- Director of Operations
- Clinical Director
- Clinical Psychologist
- Occupational Therapist
- Clinical Nurse Manager 3 (Registered Proprietor Nominee)
- Clinical Nurse Manager 2 (x2)

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.

# 8.0 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 written policy in relation to the identification of residents, which was last reviewed in February 2018. The policy included the requirements of the *Judgement Support Framework,* with the exception of the roles and responsibilities in relation to the identification of residents.

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

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

**Evidence of Implementation:** A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The approved centre used name, photograph, and date of birth of each resident as identifiers. The identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate alerts were used to inform staff of the presence of residents with the same or a similar name.

**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 5: Food and Nutrition

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** The approved centre's menus were not approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Residents had at least two choices for meals. Food was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly. Fresh water was available from jugs of water in the main seating areas.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Residents' special nutritional requirements were not regularly reviewed by a dietitian, due to the fact that there was no designated dietitian. Intake and output charts were maintained for residents, where appropriate.

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

## Regulation 6: Food Safety

**COMPLIANT**

**Quality Rating** **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to food safety. The policy included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** Food temperatures were recorded in line with food safety recommendations. A temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes. There was no evidence of a food safety audit. However, as the approved centre had recently opened, at the time of the inspection, this was deemed not applicable.

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

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

## Regulation 7: Clothing

**COMPLIANT**

**Quality Rating** **Excellent**

The registered proprietor shall ensure that:

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

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

### INSPECTION FINDINGS

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

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

**Monitoring:** The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. No resident was wearing nightclothes during the day over the course of the inspection.

**Evidence of Implementation:** Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, religious, and cultural practices. Residents had an adequate supply of individualised clothing.

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

## Regulation 8: Residents' Personal Property and Possessions

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

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

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

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

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

### INSPECTION FINDINGS

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

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

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

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

Secure facilities were provided for the safekeeping of the residents' monies, valuables, personal property, and possessions. All residents had their own separate safe in the nursing office. Each resident had a single room with a wardrobe, which had a lockable locker. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

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

## Regulation 9: Recreational Activities

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

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

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

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

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

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at recreational activities were maintained in their clinical files.

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

## Regulation 10: Religion

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable, and there was a church located next to the approved centre to support residents' religious practices. Residents had access to multi-faith chaplains, as required. Local priests visited the approved centre by request. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

## Regulation 11: Visits

**COMPLIANT**

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework* with the exception of outlining appropriate facilities in place for children visiting a resident.

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

**Monitoring:** There were no restrictions on residents' rights to receive visitors at the time of the inspection. As the approved centre had recently opened at the time of the inspection, analysis to identify opportunities to improve visiting processes was deemed not applicable.

**Evidence of Implementation:** Appropriate and reasonable visiting times were publicly displayed in the approved centre. Suitable areas were available where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. All residents were accommodated in single bedrooms or in single apartments, which could also be used for visits.

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. This was communicated to all relevant individuals publicly. The visiting areas available were suitable for visiting children.

Regulation 11: Visits was only assessed under the three pillars of processes, training and education and evidence of implementation. Monitoring was deemed not applicable.

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

## Regulation 12: Communication

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and procedures in relation to resident communication. The policy included the requirements of the *Judgement Support Framework* with the exception of the circumstances in which resident communications may be examined by a senior member of staff.

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

**Monitoring:** Resident communication needs and restrictions on communication were monitored on an ongoing basis. Analysis to identify opportunities to improve communication processes was not completed. However, as the approved centre had recently opened, at the time of the inspection, this was deemed not applicable.

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

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

## Regulation 13: Searches

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in January 2018. The policy addressed all the requirements of the *Judgement Support Framework*, including the following:

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

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

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

As there had been no searches since the approved centre opened, Regulation 13: Searches was only assessed under the two pillars of processes and training and education.

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

## Regulation 14: Care of the Dying

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and protocols in relation to care of the dying. The care of the dying policy was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework* with the exception of the process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere for different health services.

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

As there had been no deaths since the approved centre opened, Regulation 14: Care of the Dying was only assessed under the processes and training and education pillars.

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

## Regulation 15: Individual Care Plan

**NON-COMPLIANT**

**Quality Rating** Requires Improvement

**Risk Rating** HIGH

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework* with the exception of the required content in the set of documentation making up the ICP.

**Training and Education:** Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Multi-disciplinary team (MDT) members had not received training in individual care planning.

**Monitoring:** Residents' ICPs were audited, since the approved centre had opened, to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

**Evidence of Implementation:** There were four residents in the approved centre at the time of the inspection. Each resident had an ICP and all four ICPs were inspected. A key worker was identified to ensure continuity in the implementation of a resident's ICP. The ICP was not one composite set of documentation. The ICP consisted of three separate documents, which collectively formed the ICP. This included an initial care plan, the ICP action plan, and the multi-disciplinary review care plan. ICPs, stored within the clinical files, were not amalgamated with progress notes.

Each resident was not initially assessed at admission and an ICP was not completed by the admitting clinician to address immediate needs of resident. Each resident was initially assessed by Nua Healthcare's admissions department, and a subsequent admission assessment was completed once the resident had been admitted to the approved centre. One resident did not have an initial care plan completed. In three ICPs reviewed, the initial care plan had been developed by nursing staff and not the multi-disciplinary team.

All residents received a comprehensive evidenced-based assessment. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, and next of kin, as appropriate. Family were involved in residents' ICPs, with the residents' consent.

None of the ICPs identified the resident's assessed needs, appropriate goals, or the care and treatment required to meet the goals identified. However, the ICPs identified the resources required to provide the care and treatment identified. ICPs included a risk management plan. The ICP was reviewed by the MDT weekly, in consultation with the resident. The ICP was updated following review, as indicated by the

resident's changing needs, condition, circumstances, and goals. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews. When a resident declined or refused a copy of their ICP, this and the associated explanation was always not documented.

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

a) **The four ICPs were not one composite set of documentation.**
b) **The four ICPs did not specify the residents' care, treatment, or appropriate goals.**
c) **Three of the four initial ICPs were developed by nursing staff and not the multi-disciplinary team.**

## 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 the provision of therapeutic services and programmes, which was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The planning and provision of therapeutic services and programmes within the approved centre.
- Assessing residents as to the appropriateness of services and programmes (including risk).
- The resource requirements of the therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.
- The provision of therapeutic services and programmes by external providers in external locations.

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

**Monitoring:** The range of services and programmes provided in the approved centre were monitored on an ongoing basis to ensure that the assessed needs of residents were met. Analysis to identify opportunities for improving the processes relating to therapeutic services and programmes was not completed. However, as the approved centre had recently opened, at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** All therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents. All therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Adequate resources and facilities were available. The approved centre had two kitchenettes, a therapy room, a sensory garden, and a sensory room. Therapeutic services and programmes were provided in separate dedicated rooms. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents' clinical files.

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

## Regulation 18: Transfer of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

- The roles and responsibilities for the resident transfer process, including the responsibility of the multi-disciplinary team and resident's key worker.
- The interagency involvement in transfer process.
- The process for managing resident medications during transfer from the approved centre.
- The process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The process for emergency transfers.

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

As there had been no transfers since the approved centre opened, Regulation 18: Transfer of Residents was only assessed under the two pillars of processes and training and education.

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

## Regulation 19: General Health

**COMPLIANT**

**Quality Rating** **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

### INSPECTION FINDINGS

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

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

**Monitoring:** Residents' take-up of national screening programmes was recorded and monitored, where applicable.

**Evidence of Implementation:** The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator. Emergency equipment was checked weekly. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and as indicated by the residents' specific needs. No resident in the approved centre, at the time of the inspection, had been a resident for longer than six months. None of the residents were on antipsychotic medication.

Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes appropriate to their age and gender. Information on national screening programmes available was provided to residents.

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

## Regulation 20: Provision of Information to Residents

**NON-COMPLIANT**

**Quality Rating** Requires Improvement

**Risk Rating** MODERATE

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

### INSPECTION FINDINGS

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

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

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

**Evidence of Implementation:** Residents were provided with a booklet on admission that included details of mealtimes, personal property arrangements, and the complaints procedure. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were not provided with details of visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless in the resident's psychiatrist view the provision of such information was prejudicial to the resident's physical or mental health, well-being or emotional condition. The justification for restricting information regarding a resident's diagnosis was documented in their clinical care plan. Information was provided to residents on the likely adverse effects of treatment, including the risks and other potential side effects. Medication information sheets, as well as verbal information, was provided in a format appropriate to residents' needs. The content of medication information sheets did not include information on indications for use of all medications to be administered to the resident, including any possible side effects. Information

documents provided by or within the approved centre were appropriately reviewed and approved before use.

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the following information was provided to each resident:**

a) **Visiting times and visiting arrangements, 20 (1) (b).**
b) **Relevant advocacy and voluntary agencies details, 20 (1) (d).**
c) **Information on indications for use of all medications to be administered to the resident, including any possible side-effects, 20 (1) (e).**

## Regulation 21: Privacy

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a policy in relation to resident privacy. The policy addressed the requirements of the *Judgement Support Framework* with the following exceptions:

- The approved centre's layout and furnishing requirements to support resident privacy and dignity.
- The approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

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

**Monitoring:** An annual review was not completed. However, as the approved centre had recently opened at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were discreet when discussing residents' conditions or treatment needs. Residents wore clothing that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Locks had an override facility. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

Regulation 21: Privacy was only assessed under the three pillars of processes, training and education and evidence of implementation. The monitoring pillar was deemed not applicable.

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

## Regulation 22: Premises

**COMPLIANT**

**Quality Rating** **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to its premises, one of which was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework* with the exception of the provision of adequate and suitable furnishings in the approved centre.

**Training and Education:** All relevant staff had signed the signature log to indicate that they had read and understood the policy. 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 ligature audit. Documented analysis had been completed to identify opportunities for improving the premises. A hygiene audit had not been completed. However, as the approved centre had recently opened at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** The approved centre was adequately lit, heated, and ventilated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise. All resident bedrooms were appropriately sized to address residents' needs. There was sufficient indoor and outdoor space for residents to move about. Appropriate signage and sensory aids were provided to support resident orientation needs.

Hazards and ligatures had been minimised. 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. There was a cleaning schedule implemented within the approved centre. The approved centre was generally clean, hygienic, and free from offensive odours.

Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed. There was a sufficient number of toilets and showers for residents in the approved centre. The approved centre provided assisted devices and equipment to address resident needs. Remote or isolated areas of the approved centre were monitored. Back-up power was not available to the approved centre. A power outage had occurred in the approved centre and there was no back-up generator.

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

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

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for ordering resident medication.
- The process for medication reconciliation.
- The process for reviewing resident medication.
- The process for managing medication errors and/or adverse effects, including external reporting requirements.

**Training and Education:** All nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Not all nursing and medical staff had received training on the importance of reporting medication incidents, errors, or near misses.

**Monitoring:** An audit of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policy and procedures and the applicable legislation and guidelines. There were no documented incident reports for medication incidents, errors, and near misses, as staff reported that none had occurred since the approved centre had opened.

**Evidence of Implementation:** Each resident had an MPAR, four of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's MPAR. A record was kept when medication was refused by the resident. In one instance the word micrograms was not written in full, instead it was abbreviated as 'MCG'

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

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

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

**The approved centre was compliant with this regulation. The quality assessment was 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:** The approved centre had a series of written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in January 2018. The policy addressed all the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all staff had signed the signature log to indicate that they had read and understood the health and safety policy. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

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

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

## Regulation 25: Use of Closed Circuit Television

**COMPLIANT**

**Quality Rating** **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:** There was a written policy dated January 2018 in place in relation to the use of closed-circuit television (CCTV). The policy included requirements of the *Judgement Support Framework,* with the exception of the maintenance of CCTV cameras by the approved centre.

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

**Monitoring:** The quality of CCTV images was checked regularly to ensure they were operating appropriately. This was documented. There was no analysis to identify opportunities for the improvement of the use of CCTV. However, as the approved centre had recently opened at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** There were eight internal CCTV cameras, which were used solely to ensure the health and safety, and welfare of residents. CCTV cameras were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV images, used to observe residents, were only transmitted to a monitor that was viewed solely by the health professional responsible for the resident. The usage of CCTV and other monitoring systems was disclosed to the Mental Health Commission. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

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

## Regulation 26: Staffing

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and procedures in relation to staffing which was last reviewed in January 2018. The policy addressed the requirements of the *Judgement Support Framework* with the following exceptions:

- The organisational structure of the approved centre, including lines of responsibility.
- The job description requirements.
- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- 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 ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

**Monitoring:** The implementation and effectiveness of the staff-training plan was reviewed. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents was not completed. However, as the approved centre had recently opened at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** There was no organisational chart in place to identify the leadership and management structure, and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the approved centre's policy and procedures for recruitment, selection, and appointment. Staff had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time,

during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. The number and skill mix of staffing were sufficient to meet resident needs.

The approved centre did not have a written staffing plan. Opportunities were made available to staff by the approved centre for further education. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff.

Staff were trained in manual handling, infection control and prevention, management, incident reporting, and the protection of children and vulnerable adults. Staff were not trained in recovery-centred approaches to mental health care and treatment at the time of the inspection. However, Wellness Recovery Action Plan (WRAP) training had been scheduled for staff.

All health care staff were trained in the following:

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

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

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
|---|---|---|---|
| Cois Dalua | CNM 3 (Mon - Fri) | 1 | 0 |
| | CNM 2 | 1 | 0 |
| | RPN | 2 | 2 |
| | HCA | 2 | 2 |

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

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

## Regulation 27: Maintenance of Records

**NON-COMPLIANT**

**Quality Rating** Requires Improvement

**Risk Rating** LOW

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy and procedures in relation to the maintenance of records, which were last reviewed in January 2018. The policy addressed the requirements of the *Judgement Support Framework* with the following exceptions:

- Record review requirements.
- Residents' access to resident records.

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

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

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

Records were developed and maintained in a logical sequence. Two appropriate resident identifiers were not recorded on all documentation; documents containing no resident identifier were evident within the clinical files inspected. Only authorised staff made entries in residents' records, or specific sections therein. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Clinical file were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Some entries within the clinical files inspected did not include the date or the time using the 24-hour clock. The approved centre did not maintain a record of all signatures used in the resident record.

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

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in a manner to ensure completeness, accuracy, and ease of retrieval, 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 up-to-date, electronic register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

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

### INSPECTION FINDINGS

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

- The process for the development of the operating policies and procedures required by the regulations, incorporating relevant legislation, evidence-based best practice, and clinical guidelines.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The standardised operating policy and procedure layout used by the approved centre.

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

**Monitoring:** An annual audit and analysis to identify opportunities to improve the processes of developing and reviewing policies was not completed. However, as the approved centre had recently opened, at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** As the approved centre was new, and had recently opened, all of the approved centre's policies and procedures were developed in 2018. The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service-users, as appropriate. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures, required by the regulations, incorporated relevant legislation and were evidence-based. The format of the operating policies and procedures was not standardised. The format included the title, reference number and the scope of the policy and procedure. However, it omitted the document owner, total number of pages and the scheduled review date. While the approved centre adopted the HSE's Trust in Care Policy, it did not have a written statement adopting this generic policy.

Regulation 29: Operating Policies and Procedures was only assessed under the three pillars of processes, training, and education and evidence of implementation. The monitoring pillar was deemed not applicable.

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

## Regulation 30: Mental Health Tribunals

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

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

**Monitoring:** Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals. However, as the approved centre had recently opened at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:** The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff accompanied and assisted patients to attend their Mental Health Tribunal and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

As all requirements of the monitoring pillar were deemed not applicable, Regulation 30: Mental Health Tribunals was only assessed under the three pillars of processes, training and education, and evidence of implementation.

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

## Regulation 31: Complaints Procedures

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in January 2018. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

There was a nominated person responsible for dealing with all complaints available. The complaints procedure, including how to contact the nominated person was publicly displayed on the noticeboard, and it was detailed within the service-user's information booklet.

As the approved centre had not received any complaints since opening, Regulation 31: Complaints was only assessed under the two pillars of processes and training and education for this regulation.

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

## Regulation 32: Risk Management Procedures

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in January 2018. The policy addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The process of identification, assessment, treatment, reporting, and monitoring of organisational risks throughout the approved centre.
- Capacity risks relating to the number of residents in the approved centre.
- The process for maintaining and reviewing the risk register.
- The process for risk-rating incidents.
- The process for reviewing and monitoring incidents.

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

**Monitoring:** The approved centre did not have a local risk register at the time of the inspection, although there were plans to develop one. There had been no recorded patient-related incidents at the time of the inspection. However, analysis of staff-related incident reports had been completed to identify opportunities for improving risk management processes.

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

their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, and monitored, but were not recorded in a local risk register. Individual risk assessments were completed at admission and in conjunction with medication requirements or medication administration. While structural risks, including ligature points, remained evident within the approved centre at the time of the inspection, these were effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were recorded on Nua Healthcare's incident reporting system (AIRS) but these were not risk-rated in a standardised format. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

## Regulation 33: Insurance

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre's insurance certificates were provided to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity, and property.

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

## Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently in the reception area of the approved centre.

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

# 9.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

# 10.0 Inspection Findings – Mental Health Act 2001

Part 4 of The Mental Health Act 2001 Consent to Treatment was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

# 11.0 Inspection Findings – Codes of Practice

Three of the four Codes of Practice were not applicable to this approved centre at the time of the inspection. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. All policies were reviewed in January 2018; all policies combined included all of the policy related criteria of the code of practice.

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

**Monitoring:** An audit of the implementation of and adherence to the admission policy was not completed. However, as the approved centre had recently opened at the time of the inspection, this was deemed not applicable.

**Evidence of Implementation:**

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

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

**Discharge:** There were no discharges since the approved centre opened, at the time of the inspection.

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

Appendix 1: Corrective and Preventative Action Plan Template – Cois Dalua - 2018 Inspection Report

# Regulation 15: Individual Care Plan

***Report reference: Pages 28 & 29***

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 1. The four ICPs were not one composite set of documentation. | *New* | Corrective Action(s):<br>➢ A revised Individualised Care Plan has been developed and implemented in the approved centre in line with Regulation 15 (4.1) of the MHC Judgement Support Framework.<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | Note: The implementation of the individual care planning processes, are monitored and continuously improved in line with the following methods:<br>➢ Weekly MDT reviews held by the Clinical Director<br>➢ Regular auditing and review by our internal quality auditing system in line with the MHC Judgement Support Framework | ➢ No such barriers exist in the implementation of this action and is subsequently closed. | ➢ 21/02/2019 [Closed] |
| | | Preventative Action(s):<br>➢ Regular auditing and review by our internal quality auditing system<br>Post-Holder(s) responsible:<br>➢ Eileen Madigan (CNM3)<br>➢ Chris Hindle (Registered Proprietor) | ➢ Individual care plans are audited on a 6-monthly basis to assess compliance with Regulation 15.<br>➢ Analysis is completed to identify opportunities to improve the individual care planning process. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/05/2019 |
| 2. The four ICPs did not specify the residents' care, treatment, or appropriate goals. | *New* | Corrective Action(s):<br>➢ A revised Individualised Care Plan has been developed and implemented in the approved centre in line with Regulation 15 - (4.8 & 4.9) of the MHC Judgement Support Framework<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | Note: The implementation of the individual care planning processes, are monitored and continuously improved in line with the following methods:<br>➢ Weekly MDT reviews held by the Clinical Director<br>➢ Regular auditing and review by our internal quality auditing system in line with the MHC Judgement Support Framework | ➢ No such barriers exist in the implementation of this action and is subsequently closed. | ➢ 21/02/2019 [Closed] |

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|---|---|---|---|---|---|
| | | | | | |
| | | Preventative Action(s):<br>➢ Regular auditing and review by our internal quality auditing system<br>Post-Holder(s) responsible:<br>➢ Eileen Madigan (CNM3)<br>➢ Chris Hindle (Registered Proprietor) | ➢ Individual care plans are audited on a 6-monthly basis to assess compliance with Regulation 15.<br>➢ Analysis is completed to identify opportunities to improve the individual care planning process. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/05/2019 |
| 3. Three of the four initial ICPs were developed by nursing staff and not the multi-disciplinary team | *New* | Corrective Action(s):<br>➢ A revised Individualised Care Plan has been developed and implemented in the approved centre in line with Regulation 15 - (4.3, 4.4 & 4.14) of the MHC Judgement Support Framework<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | Note: The implementation of the individual care planning processes, are monitored and continuously improved in line with the following methods:<br>➢ Weekly MDT reviews held by the Clinical Director.<br>➢ Regular auditing and review by our internal quality auditing system in line with the MHC Judgement Support Framework. | ➢ No such barriers exist in the implementation of this action and is subsequently closed. | ➢ 21/02/2019 [Closed] |
| | | Preventative Action(s):<br>➢ Regular auditing and review by our internal quality auditing system<br>Post-Holder(s) responsible:<br>➢ Eileen Madigan (CNM3)<br>➢ Chris Hindle (Registered Proprietor) | ➢ Individual care plans are audited on a 6-monthly basis to assess compliance with Regulation 15.<br>➢ Analysis is completed to identify opportunities to further improve the Individual Care Planning process in line with developing best practice. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/05/2019 |

## Regulation 20: Provision of Information to Residents

*Report reference: Pages 33 & 34*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| 4. The registered proprietor did not ensure that the following information was provided to each resident: Visiting times and visiting arrangements, 20 (1) (b). | *New* | Corrective Action(s):<br>➢ Visiting times are now clearly displayed in the entrance hall of the centre. It is also included more explicitly in both the Statements of Purpose & Function and in the Easy Read Version and in the Visiting Policy.<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | ➢ The provision of information to residents is monitored on an ongoing basis to ensure the information is appropriate and accurate, particularly where information changes. | ➢ No such barriers exist in the implementation of this action and is subsequently closed. | ➢ 21/02/2019 [Closed] |
| | | Preventative Action(s):<br>➢ The implementation of the policy on the provision of information to resident's regulation 20 is monitored and continuously improved.<br>➢ Regular auditing and review by our internal quality auditing system.<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | ➢ Analysis is completed to identify opportunities to improve the processes for providing information to residents.<br>➢ Audits are conducted on a 6-monthly basis by our quality assurance team to assess compliance with Regulation 20. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/05/2019 |
| 5. The registered proprietor did not ensure that the following information was provided to each resident: Relevant advocacy and | *New* | Corrective Action(s):<br>➢ There is now a poster displayed in the living area with all contact details provided for residents. The policy has also been updated.<br>➢ Centre Management have contacted the Cork Branch of the Irish Advocacy | ➢ The provision of information to residents is monitored on an ongoing basis to ensure the information is appropriate and accurate, particularly | ➢ No such barriers exist in the implementation of this action. | ➢ 01/04/2019 |

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|---|---|---|---|---|---|
| voluntary agencies details, 20 (1) (d). | | Association and they plan to attend the centre in March 2019 to arrange regular visits and consultation.<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | where information changes. | | |
| | | Preventative Action(s):<br>➢ The implementation of the policy on the provision of information to resident's regulation 20 is monitored and continuously improved.<br>➢ Regular auditing and review by our internal quality auditing system<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | ➢ Analysis is completed to identify opportunities to improve the processes for providing information to residents.<br>➢ Audits are conducted on a 6-monthly basis by our quality assurance team to assess compliance with Regulation 20. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/05/2019 |
| 6. The registered proprietor did not ensure that the following information was provided to each resident: Information on indications for use of all medications to be administered to the resident, including any possible side-effects, 20 (1) (e). | *New* | Corrective Action(s):<br>➢ Medication information now available on request. Information folders stored in the office and can be viewed on request by the residents. Notification of same displayed in living area.<br>➢ Updating information leaflets on a regular basis. Residents now informed as part of the Community meeting.<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor) | ➢ The provision of information to residents is monitored on an ongoing basis to ensure the information is appropriate and accurate, particularly where information changes. | ➢ No such barriers exist in the implementation of this action and is subsequently closed | ➢ 21/02/2019 [Closed] |

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|---|---|---|---|---|---|
| | | ➢ Eileen Madigan (CNM3) | | | |
| | | Preventative Action(s):<br>➢ The implementation of the policy on the provision of information to resident's regulation 20 is monitored and continuously improved.<br>➢ Regular auditing and review by our internal quality auditing system<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | ➢ Analysis is completed to identify opportunities to improve the processes for providing information to residents.<br>➢ Audits are conducted on a 6-monthly basis by our quality assurance team to assess compliance with Regulation 20. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/04/2019 |

## Regulation 27: Maintenance of records

*Report reference: Pages 44 & 45*

| Area(s) of non-compliance | | Specific | Measureable | Achievable / Realistic | Time-bound |
|---|---|---|---|---|---|
| The registered proprietor did not ensure that records were maintained in a manner to ensure completeness, accuracy, and ease of retrieval, 27(1). | *New* | Corrective Action(s):<br>➢ Centre Management have conducted a full review to ensure that records are maintained in a manner to ensure completeness, accuracy, and ease of retrieval.<br>➢ Each resident file and all other documentation now have two unique identifiers; one being a photograph of the resident at the front of their file and the other their MRN number. The medical passport stored in the residents file also includes a picture.<br>➢ A record log of all staff signatures used in resident records is now available. This is stored in a folder in the main office of the Approved Centre and identified as such.<br>➢ Policy relevant to regulation 27 has been updated to reflect the above.<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | ➢ Residents' access to their records is managed in accordance to the Data Protection Acts.<br>➢ The Mental Health Administrator for Cois Dalua will ensure that records are maintained in a manner to ensure completeness, accuracy, and ease of retrieval. | ➢ No such barriers exist in the implementation of this action and is subsequently closed. | ➢ 21/02/2019 [Closed] |

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|---|---|---|---|---|---|
| | | | | | |
| | | Preventative Action(s):<br>➢ The implementation of the policy on maintenance of resident's records regulation 27 is monitored and continuously improved.<br>➢ Regular auditing and review by our internal quality auditing system<br>Post-Holder(s) responsible:<br>➢ Chris Hindle (Registered Proprietor)<br>➢ Eileen Madigan (CNM3) | ➢ Analysis is completed to identify opportunities to improve the processes for providing information to residents.<br>➢ Audits are conducted on a 6-monthly basis by our quality assurance team to assess compliance with Regulation 20. | ➢ No such barriers exist in the implementation of this action. | ➢ 01/05/2019 |