Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME:	Highfield Hospital
IDENTIFICATION NUMBER:	AC088
APPROVED CENTRE TYPE:	Adult Admission Unit and Psychiatry of Later Life
REGISTERED PROPRIETOR:	Mr Stephen Eustace
REGISTERED PROPRIETOR NOMINEE:	N/A
MOST RECENT REGISTRATION DATE:	30 March 2015
NUMBER OF RESIDENTS REGISTERED FOR:	110
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	9, 10, 11 November 2015
PREVIOUS INSPECTION DATE:	6 and 7 May 2014
CONDITIONS ATTACHED:	None
LEAD INSPECTOR:	Mr Donal O' Gorman
INSPECTION TEAM:	Ms Orla O'Neill
THE INSPECTOR OF MENTAL HEALTH SERVICES:	Dr Susan Finnerty MCN009711 (Acting)

Contents

1.0 Mental Health Commission Inspection Process

The principal functions of the 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 under this Act.

The Mental Health Commission strives to ensure its principal legislative functions are achieved through the registration 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). 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 Mental Health Act (2001), 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, and
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 shall be assessed against all regulations, rules, codes of practice and Section 4 of the Mental Health Act 2001 at least once on an annual basis. Inspectors shall use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined the individual regulation, or rule, shall also be risk assessed.

The approved centre is required to act on all aspects identified as non-compliant or with a high / critical risk rating. Demonstration of immediate corrective rectifications, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and time-bound. All actions must have identified timeframes and responsibilities.

A copy of the draft report was forwarded to the service and comments and review on the report were invited from the Registered Proprietor. These comments were reviewed by the lead inspector and incorporated into the report, where relevant.

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health 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 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

Highfield Hospital was an independent sector approved centre registered for 110 residents. The recently built (2010) hospital complex was located on the Swords Road, Dublin, amid well-kept parkland. The original hospital had been established in 1825 by Dr John Eustace, and the hospital was now run by fifth and sixth generations of the Eustace family. The premises were modern and spacious and accommodation in Hampstead Unit was in single, en suite rooms. Highfield Hospital approved centre comprised a 10-bed acute adult psychiatric unit, and five psychiatry of old age units - Steele, Tuke, Domville, Pinel and Farnham.
There were 108 residents on the day of inspection. All residents in Hampstead unit were voluntary. In Steele unit there was one detained patient and there were twelve residents in total in the approved centre who were Wards of Court.

2.2 Governance

The service provided the inspection team with copies of the minutes of Executive Management Meetings. These minutes showed evidence of regular senior management meetings with issues like service development and staff training and development being regularly discussed.

2.3 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against with the exception of Regulation 17 Admission of Children, the Rules on ECT and Seclusion and the Codes of Practice on the Use of ECT for Voluntary Patients and on the Admission of Children, which were not applicable.

The inspection was undertaken onsite in the approved entre from:

9 November 2015 09.30 to: 11 November 2015 16.30

2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 6 and 7 May 2014 identified the following areas that were not fully compliant:

Regulation/Rule/Act/Code	Inspection Findings 2015
Regulation 15: Individual Care Plan	Compliant
Regulation 16: Therapeutic Services	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Compliant
Rules: Mechanical Restraint	Compliant
COP: Admission, Transfer and Discharge	Compliant

2.5 Conditions to Registration

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

2.6 Non-compliant areas on this inspection

The approved centre was compliant in all areas on this inspection.

2.7 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 11: Visits
Regulation 14: Care of the Dying
Regulation 15: Individual Care Plan
Regulation 22: Premises
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 24: Health and Safety
Regulation 28: Register of Residents
Regulation 30: Mental Health Tribunals
Regulation 32: Risk Management
Regulation 33: Insurance
Regulation 34: Certificate of Registration
Rules on Mechanical Restraint
COP Physical Restraint
COP Notification of Deaths and Incident Reporting

2.8 Areas of good practice identified on this inspection

- Staff were knowledgeable about individual residents, their care and treatment and residents' interests and preferences. Interactions between staff and residents was observed to be calm, relaxed, friendly and respectful.
- There was an individual care plan (ICP) for each resident and these were of a very good standard throughout the service. The care plans captured residents' needs, goals and expectations with strong evidence of resident, family and multi-disciplinary team members' input.

2.9 Reporting on the National Clinical Guidelines

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

2.10 Resident Interviews

The inspection team met with one resident on Hampstead unit. The resident was very complimentary in relation to the care and treatment they had received since their admission to the unit. The resident reported that the nursing staff were very supportive and helpful, and that the therapeutic services provided were facilitating good recovery.

2.11 Feedback Meeting

- Director of Nursing
- Clinical Services Manager
- Mental Health Act Administrator
- Clinical Director
- Psychologist
- Clinical Nurse Manager (CNM) 3
- 2 x CNM1s
- Staff Nurse
- 2 x Occupational Therapist
- Consultant Psychiatrist
- Director of Services
- Cognitive Behavioural Therapist
- Quality and Risk Manager
- Medical Intern

The approved centre's senior management team informed the inspection team about recent quality initiatives undertaken by the service which included a substantial review of all policies in line with the Judgement Support Framework and a brief discussion on the strategic plans to extend Adult Services and to establish a day hospital. The management team also reported on the establishment of SAGE (Support and Advocacy Service for Older People) as resident Advocacy service, the introduction of weekly activity reports, the roll out of a survey on Recovery, the appointment of a dedicated Quality and Risk Manager and Sonas Programmes (Activating Potential Communication) running in all units.

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001 **EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)**

3.1 Regulation 1: Citation
Not Applicable

3.2 Regulation 2: Commencement
Not Applicable

3.3 Regulation 3: Definitions
Not Applicable

3.4 Regulation 4: Identification of Residents

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: There was a policy in place in relation to the identification of residents. The policy required each resident to be identified using name, photograph, date of birth and medical record number (MRN).
As the approved centre had mostly long-term residents, the residents were known to medical and nursing staff. The residents in Hampstead unit were identified via name and medical record number.

Training: Staff were aware of the policy and process on the identification of residents.

Monitoring of Compliance: There had been an annual audit on identification processes undertaken.

Evidence of Implementation: Steele, Pinel, Tuke, Domville and Farnham units all used names and photographs as resident identifiers. In Hampstead unit, name/address and medical record number were used as resident identifiers. The approved centre had a Red Alert labelling system in place in the event of same name residents.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.5 Regulation 5: Food and Nutrition

(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 roles and responsibilities for the provision and management of food and meals within the approved centre were clearly established. All meals were prepared by the main kitchen and the catering manager was responsible for oversight. Food was delivered to the units in heated food trolleys and both nursing staff and healthcare assistants served the meals to the residents.

Training: Nursing staff and healthcare assistants (HCAs) were trained in the monitoring of food intake and food safety.

Monitoring of Compliance: Nursing staff completed weekly weight charts for each resident on the continuing care units.

A Malnutrition Universal Screening Tool (MUST) was also used by nursing staff with speech and language therapy (SALT) and dietician input into resident nutrition and eating needs. An annual audit had been undertaken to determine compliance with the processes.

Evidence of Implementation: The inspection team interviewed the catering manager, nursing staff and healthcare assistants about the provision of meals, diets and nutrition assessments. The inspection team visited the dining rooms in Domville, Pinel and Tuke units and observed food being served. The lunch was hot and freshly plated up for each resident and served to them in their respective dining rooms. There was a good choice of meals, a menu was available and picture cards of different meals and special diets were available and on display in servery areas attached to each dining room. Food intake assessments and weight/MUST charts were evident in the clinical files and individual care plans. Fresh drinking water and hot and cold drinks were available on all units.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.6 Regulation 6: Food Safety

(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 catering manager of Highfield Hospital was responsible for the provision and management of food within the service. On inspection of the main kitchen area, it was evident that there was a clear process in relation to food preparation, storage, distribution and disposal.

Training: Relevant catering staff had received training in the safe handling of food, Hazard Analysis and Critical Control Points (HACCP) and food hygiene. Catering staff were observed to wear appropriate protective clothing.

Monitoring of Compliance: There was evidence of food audits being carried out and the Environmental Health Officer's most recent report was made available to the inspection team.

Evidence of Implementation: The inspection team met with the catering manager and visited three of the approved centre's dining room facilities on Pinel, Tuke and Domville units.
The dining rooms were clean, uncluttered, bright and spacious. The servery kitchens contained heated food trolleys and refrigeration and the food was delivered fully cooked to the units. Catering staff checked, recorded and monitored food temperatures and the temperature of the refrigerator.
Table settings comprised appropriate cutlery, napkins and crockery.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.7 Regulation 7: Clothing

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: There was a process in place for organising clothing for residents in the approved centre.

Training: The induction process for nursing staff and healthcare assistants addressed resident clothing.

Monitoring of Compliance: An audit was completed on residents' personal clothing.

Evidence of Implementation: All residents observed were dressed in their day clothes and were neatly groomed and attired. All the residents had their own wardrobes and lockable bedside lockers in single en suite rooms. In Hampstead unit, residents managed their own clothing. On Pinel and Domville units, residents' clothes were individually labelled with residents' names on same. On Steele, Tuke and Farnham units, residents had their own supply of clothes which were individualised.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.8 Regulation 8: Residents' Personal Property and Possessions

(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 policy on residents' personal property and possessions. A property checklist was completed for each resident, at the time of admission, and countersigned by a member of nursing staff. As admissions to Highfield Hospital were planned, residents and their families were given information relating to personal property and possessions.

Training: The nursing staff induction programme addressed the management of residents' property and possessions. This included associated risk assessment.

Monitoring of Compliance: There was no evidence of an audit having been completed on the implementation of this process.

Evidence of Implementation: There was a safe, lockable press for storage and safeguarding of residents' monies and valuables on the units. Residents could keep personal items locked in their bedside lockers. Copies of property checklists were kept in residents' files, separate from individual care plans. On each unit, all residents had their own individual property register booklet for their personal property and possessions. Residents' monies retained on the unit were stored in a safe locked press and signed off by two members of staff.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a process in place to facilitate recreational activities for residents.

Training: Staff were aware of the processes for involving residents in recreational activities and this was captured and documented in the induction training programme.

Monitoring of Compliance: Residents' engagement with recreational activities was monitored by their multi-disciplinary team (MDT) and reflected in ICPs. There had been one audit carried out in relation to compliance with this regulation (Patient Satisfaction Questionnaire).

Evidence of Implementation: Two staff were employed as activities therapists. There was a timetable of activities posted in the residential mental health units (Pinel, Tuke, Steele, Domville and Farnham). The occupational therapist (OT) had completed assessments of individual residents to assess abilities to engage in activities and related needs. The OT used a MOHOST (Model of Human Occupation Screening Tool) and this provided information to match residents' needs and the activities provided. The activities therapist documented resident participation in their clinical files and this included information on resident outings, music and singing sessions, painting, baking, walking groups and relaxation.
There were books, table games, a television and DVD player in each unit and television in all rooms. Gym facilities were available to Hampstead residents.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: There was a policy entitled *Pastoral Care* which set out the processes for facilitating religious practices within the approved centre.

Training: Staff were aware of and understood the processes in facilitating residents in the practice of their religion and this was covered in staff induction.

Monitoring of Compliance: Staff monitored residents' religious preferences and engagement in religious observance. However, there was no other evidence of audit or monitoring of residents' needs for support in relation to religious practice.

Evidence of Implementation: The admission assessment of each resident completed by a member of nursing staff identified the resident's spiritual and religious preferences and beliefs. There was a contact list available of ministers of various faiths and staff could access this from the hospital chaplain. End of life care and religious preferences were facilitated in the continuing care units. Roman Catholic Mass was celebrated regularly in the approved centre's large oratory and residents were supported to attend Mass.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.11 Regulation 11: Visits

(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: There was a policy relating to visits and there was a process for facilitating visitors to the approved centre, including children.

Training: Staff were aware of the arrangements relating to visiting and this was covered in Induction training. Relevant staff also received training in the *Protection of Vulnerable Adults and Child Protection Principles*.

Monitoring of Compliance: There was evidence that processes in relation to visits had been reviewed. Nursing staff monitored how resident visits went and, where necessary, recorded visits in the resident's clinical file.

Evidence of Implementation: Visiting times were displayed at the main reception area and at the entrances of all the units. Discussion with nursing staff indicated that visiting times were flexible and visitor rooms were available on the main approved centre's corridor for both families and children. Staff explained the visiting arrangements to residents and that they could decline visits from a specific visitor, should they wish. This information was also available in the Resident Information Booklet.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.12 Regulation 12: Communication

(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: There was a policy on communication. This policy addressed residents' communication needs and functional abilities and outlined how staff should evaluate and support residents' communication needs. There was also a policy on *Resident Correspondence* which addressed residents' communication rights and procedures for communicating with families and friends by letter, email or telephone.

Training: Staff were aware of the policies and procedures for resident communication. This was not documented.

Monitoring of Compliance: Residents' communication needs were monitored by the MDT and recorded in the ICP. There was no annual audit completed. The service issued a *Patient Satisfaction Questionnaire* to all discharged residents.

Evidence of Implementation: The inspection team spoke to nursing staff and examined the residents' unit meeting log and information booklet to examine the procedures in relation to communication. Residents were permitted to retain their own mobile phone and laptop in Hampstead unit. Residents on the continuing care units had access to a cordless telephone and staff supported residents with cognitive impairments to make calls. There was a daily postal service available from the main reception desk where residents could send and receive mail. Stamps were available at reception and letters were franked for residents. There was a contact list for interpretation services and staff knew how to order this service if needed. The wireless internet signal was poor as reported to the inspection team and residents had complained about this. Relevant staff were addressing this issue.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy in place relating to carrying out searches. The policy covered the requirements outlined in the regulation, including the procedure in undertaking a search for illicit substances and carrying out searches with and without consent.

Training: Staff interviewed were aware of the policy relating to resident searches.

Monitoring of Compliance: There was no evidence presented of formal audit of compliance with the required processes.

Evidence of Implementation: One resident on Hampstead unit had their property searched as evident from their clinical file. A risk assessment had been undertaken and the consent of the resident had been obtained. The search had been undertaken by two members of nursing staff and had been documented in both nursing and medical notes. The reason for the resident search was also reflected in their ICP. The search policy was communicated to residents on admission and through the Resident Information Handbook.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.14 Regulation 14: Care of the Dying

(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: There was a comprehensive policy on *End of Life Care* in the approved centre. The policy covered the reporting of deaths, including the completion of death notification forms and their submission to the Mental Health Commission (MHC) and the management of sudden death. The policy also included the identification and implementation of residents' physical, emotional, social and spiritual needs in relation to their care.

Training: The area of dying, death and bereavement was covered in staff induction training which was documented.

Monitoring of Compliance: There was an audit completed by the approved centre on care of the dying.

Evidence of Implementation: There were residents in the approved centre for whom a DNAR order was prescribed and these were in operation at the time of inspection. These were documented in the clinical files. In the clinical files inspected on Tuke and Pinel units, there was evidence of good pain management.

The single rooms afforded the residents and their families' privacy and dignity and pastoral care involvement. Good timeframes were evidenced in the ICPs on both units reflecting the physical, social and emotional needs of the resident in relation to end of life. The deaths of residents in Highfield Hospital had been notified to the MHC within the appropriate timeframe.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.15 Regulation 15: Individual Care Plan

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

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

Inspection Findings

Processes: There was a process for the development and review of ICPs and multi-disciplinary team involvement with ICPs.

Training: Staff were aware of the processes and procedures for ICPs. ICPs were included in the staff induction training programme and the clinical services manager had facilitated training sessions.

Monitoring of Compliance: The approved centre had completed monthly audits of ICPs and audit results had been reviewed at clinical staff meetings.

Evidence of Implementation: Each clinical file inspected contained an ICP. Each ICP recorded identified needs, goals, actions and intervention review and outcome. Resident expectations and resident signatures were recorded and, where a resident did not sign or contribute to the ICP, the reason for same was also recorded. There was an ICP index sheet recorded in each ICP and this headlined the key goals and areas of concern for that resident. The ICPs featured a comprehensive range of care domains and the focus was on recovery and community living for residents on Hampstead unit.

Families did not attend the MDT review meetings but it was evident that residents' families had input into residents' care and were kept informed of any changes. Family meetings were regularly convened with residents' consent. Individual risk assessment was integral as evidenced in the ICP. Residents and their families were informed about the ICP in the Resident Information Booklet.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.16 Regulation 16: Therapeutic Services and Programmes

(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: There was a policy entitled *Therapies*. The MDT was charged with responsibility to ensure that each resident was provided with a range and mix of therapeutic interventions appropriate with assessed needs. This range included nursing, medical, social work, occupational therapy, psychology and other interventions depending on the needs of the resident.

Training: The service had two activities therapists trained in specific and suitable activities for older residents. Staff were cognisant of the policy and procedures for therapeutic services and programmes and their own role and responsibilities.

Monitoring of Compliance: The delivery of therapeutic services and programmes and individual uptake, engagement and outcome were recorded in the residents' ICPs. There was no audit undertaken to determine compliance with the processes.

Evidence of Implementation: Each resident had access to therapeutic services and programmes in accordance with their ICPs. The ICPs specified domains of care that addressed physical, psychological and social functioning needs of each resident. The therapeutic services provided were based on assessed needs in these domains and were aimed at either maintaining or restoring optimal functioning in these areas. Assessments undertaken by each discipline were evidence-based and supported outcome evaluations. There was a timetable of therapeutic programmes in Hampstead unit displayed for residents. There was evidence of MDT input and involvement as staff liaised with each other to ensure a balance was maintained in the scheduled programme between reflective talking therapies, mindfulness, coping skills group and physical well-being. Each discipline recorded therapeutic engagement and outcomes in the clinical files and each discipline used an identifying colour label (e.g. nursing, OT and psychology) to record progress and outcomes.

It was evident that therapeutic provision was mindful of residents' living environment on discharge and residents' abilities to cope – a recovery ethos was evident and had been evaluated from a resident perspective. Therapeutic programmes included: peer group support; emotional regulation groups; mindfulness groups; cognitive behaviour therapy group; and anxiety management.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.17 Regulation 17: Children's Education

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

Inspection Findings

As children were not admitted to the approved centre, this regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

3.18 Regulation 18: Transfer of Residents

(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: There was a policy on the transfer of residents. The policy outlined the required documentation to be sent with a resident upon transfer.

Training: Staff were aware of the policy and their roles and responsibilities in relation to the processes. This was not documented.

Monitoring of Compliance: Each unit maintained an admission, transfer and discharge log book of residents. This was monitored by both medical and nursing staff. There was no evidence of audit of transfers provided.

Evidence of Implementation: No resident was out of the approved centre on transfer.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

Inspection Findings

Processes: The approved centre had a policy on medical emergencies and processes covering the provision of general healthcare.

Training: All medical and nursing staff had been trained in the management of general healthcare processes as part of their professional competencies and staff were trained on medical emergencies and general health assessments as part of the induction training.

Monitoring of Compliance: There was no evidence of formal audit of compliance with processes.

Evidence of Implementation: All residents had access to medical and nursing intervention in relation to general health issues. Appropriate facilities were available to safeguard the privacy and dignity of residents receiving general healthcare. Interventions were in line with the requirements of the residents' ICPs. A number of residents had been over six months continuously in the centre and there was evidence on their clinical files that the six-monthly reviews had been completed. Staff had access to an Automatic Emergency Defibrillator which was located at the main entrance of the centre; weekly checks of this were carried out. There was evidence in three of the clinical files that residents had been offered appointments for national screening programmes. One resident on Pinel Unit had attended Bowel Screening and two residents on Steele Unit had attended Breast Check.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.20 Regulation 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

Inspection Findings

Processes: There was a policy on the provision of information to residents. There was an additional policy entitled *Residents' Rights* which addressed the residents' rights to information on advocacy and making complaints.

Training: Staff were aware of residents' rights to the provision of information and this was reflected in the induction training programme.

Monitoring of Compliance: A new information leaflet had been recently introduced as a quality initiative; there was no evidence of audits undertaken.

Evidence of Implementation: There were information boards on each unit. Information on boards included: how to make a complaint; patients' charter of rights; advocacy services; therapeutic programmes; housekeeping practices; timetables; and members of the unit's MDT. There were information leaflets provided to residents and their families on medications and diagnoses.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There was a policy and processes for the provision of privacy. The policy required staff to be mindful of respecting residents' privacy at all times. There were clear protocols in relation to privacy and confidentiality in the provision of all healthcare procedures to residents.

Training: Staff were informed about the protocols for ensuring privacy during their induction process. Relevant staff were also trained in elder abuse (awareness and prevention) and *Safeguarding Vulnerable Adults*.

Monitoring of Compliance: The implementation of processes for privacy was monitored through a resident satisfaction survey only. No audit was undertaken.

Evidence of Implementation: Bedrooms were single en suite which afforded residents privacy. Residents who required assistance with self-care, such as bathing, and assistance with eating were observed to be treated in a respectful manner and with sufficient staff numbers to ensure dignity and respect.
There were sufficient clinical rooms and areas on each unit so that resident examinations, procedures and interviews could take place in privacy. Residents were observed to be called by their preferred name. There was no confidential resident information on display on any of the units inspected.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.22 Regulation 22: Premises

(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: There were defined processes for managing the premises to ensure safety and suitability to the needs of the residents. The Registered Proprietor and heads of departments, such as the Housekeeping and Maintenance Departments, were responsible for the cleanliness and upkeep of the premises respectively. There was a process in place for requesting maintenance works and for tracking outcomes. There was also a process for infection control, weekly unit environment checks and a process for regular cleaning, checking and servicing of equipment.

Training: Staff interviewed were aware of the processes and procedures for maintaining a suitable environment and of their roles and responsibilities.

Monitoring of Compliance: There was regular monitoring of equipment such as fire equipment, water testing, lighting, lifts, electric beds and hoists. Incident reports were completed for issues relating to premises and issues were reviewed by the Health and Safety Committee. Outcomes were reported to the approved centre's Quality and Risk Management Committee. Audits were completed on cleaning and infection control.

Evidence of Implementation: The premises was spacious, bright, modern and well designed with access to both internal and outdoor communal areas. The grounds and internal courtyards were well designed with walkways and paved areas covered with soft underlying synthetic material which would provide protection to residents in the event of a fall.
Each unit inspected was clean and brightly lit with a sufficient supply of fixtures and fittings appropriate to the needs of the particular resident group accommodated in that unit. All areas were wheelchair-accessible with ample assisted baths and showers. The temperature

of the bedrooms was observed to be comfortable and temperature could be adjusted locally by staff, if required. All fixtures and fittings on Hampstead unit were anti-ligature.

Consideration had been given to the décor in creating an attractive living environment as each unit had an array of colourful art work with one unit having a replica bar counter feature.

There was a café and seating area in the reception area for the use of both residents and visitors. This featured a gas fire, comfortable couches and television.

The premises was adequately lit, ventilated and heated.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

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

(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 comprehensive policy relating to medications. The policy outlined the responsibilities in relation to the ordering, prescribing, storing and administering of medication. Medications were ordered from an external pharmacy by staff nurses as well as the CNMs on each unit.

Training: Only qualified clinical staff handled medications. Staff were aware of the process of medication incident reporting and this was covered in induction training.

Monitoring of Compliance: There was evidence of audit having been undertaken on the ordering, receiving and storage of medication.

Evidence of Implementation: Medication was procured, stored and administered in accordance with legal requirements. A medication administration record (Kardex) was maintained for each resident. Controlled drugs were stored securely in a locked press and two nurses signed for the administration of a controlled drug. Drugs currently in use were stored in the drugs trolley, which was locked and a supply of medication was also maintained in a locked press. All 28 medication administration records inspected contained the required Medical Council Registration Number (MCN) of the prescriber, including National Midwifery Board of Ireland (NMBI) numbers of nursing staff administering the medications to the residents. Medications requiring refrigeration were appropriately stored and a temperature log of the fridge maintained. Regular inventory of medication stock was undertaken by nursing staff on each unit.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a Health and Safety Statement and policy which included reference to staff, residents and visitors. There was a hazard identification and risk control analysis completed for each unit and this was updated annually.

Training: Staff signed a training log to indicate having read and understood the Health and Safety Statement. Health and safety was also included in the staff induction programme.

Monitoring of Compliance: Audits and incident reports had been completed for health and safety related incidents and incidents were reviewed by the Health and Safety and Quality and Risk committees.

Evidence of Implementation: There were two health and safety staff representatives in the approved centre. The Health and Safety Committee met regularly to ensure a responsive approach to health and safety issues, which were acted on promptly. There were two risk management consultants who had input to health and safety and quality and risk committees and provided recommendations for quality improvement.
Staff training records were up to date for fire training, fire safety and drills, manual handling, infection control, hand washing and CPR.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.25 Regulation 25: Use of Closed Circuit Television (CCTV)

(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 anytime on request.

Inspection Findings

Processes: There was a policy on the use of CCTV in the approved centre. CCTV in the approved centre was used for security reasons only, no CCTV was present in resident areas. There was clear signage on the use of CCTV in place throughout the approved centre.

Training: Staff were made aware of the use of CCTV during their Induction training.

Monitoring of Compliance: An annual audit on the use of CCTV had been recently undertaken in the approved centre on 14 September 2015. However, it had not been fully completed.

Evidence of Implementation: The CCTV system was incapable of recording or storing images. The use of CCTV was disclosed to the inspection team. CCTV cameras were located only at main reception, exit points and external locations (car park).

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.26 Regulation 26: Staffing

(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 policy on the recruitment and selection of staff.

Training: Staff were aware of the requirements of the staffing policies and had received training, but this was not documented. There was a comprehensive induction training process in place for newly appointed staff and there was evidence that relevant staff had completed mandatory training.

Monitoring of Compliance: No annual audit was undertaken on the implementation of the processes.

Evidence of Implementation: The inspection team met with nursing staff and healthcare assistants, including the occupational therapist and psychologist, along with members from the senior management team during the inspection. The staff training record was maintained and monitored. Crisis Prevention Institute (CPI) training was up to date as was training in CPR, fire training and manual handling. Two personnel files were examined and both included appropriate training in relation to role, Garda vetting, confirmation of identity, professional registration as appropriate, job description and contract of employment. Residents had access to medical, nursing, social work, occupational therapy and psychology staff. Discussions with staff within the units and the senior managers highlighted issues in relation to the recruitment of staff. However, the approved centre actively engaged in the recruitment process for nursing staff. There was an appropriately qualified member of staff in charge at all times in the approved centre. Nursing staff were aware of the Mental Health Act 2001 rules and regulations and copies of the Act were available on the units.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.27 Regulation 27: Maintenance of Records

(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 policy on the creation of, access to, retention of and destruction of records.

Training: Staff were aware of this policy and had received training during induction on issues relating to record maintenance. HCAs did not have access to resident records.

Monitoring of Compliance: Evidence of audit was not available. There were no incident records logged relating to the maintenance of records.

Evidence of Implementation: All clinical files examined during the inspection were in good working order. They were well structured with appropriate divisions into relevant sections such as clinical notes, medical interventions and tests, individual care plan and risk assessments. There was evidence of relevant disciplines contributing to the clinical notes.

Records were updated and maintained by appropriate staff, were securely stored and contained within a single file.

The most recent Fire Inspection and Environmental Health Officer's reports were made available to the inspection team.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.28 Regulation 28: Register of Residents

(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 Register was maintained in hard copy on each unit and contained all the data fields required by Schedule 1 to the Regulations.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.29 Regulation 29: Operating Policies and Procedures

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: There was a process for developing and reviewing policies and procedures. This process included dissemination of the policies to the relevant heads of disciplines.

Training: Staff were trained commensurate with their roles and were aware of the processes for developing and approving policies.

Monitoring of Compliance: A new policy committee was established to ensure all policies and procedures were being reviewed and updated. There was no evidence of audit completed.

Evidence of Implementation: The policies and procedures required by the regulations, rules and codes of practice were in place and reviewed as required. Policies were provided to staff by their line managers and were visibly accessible in unit offices. The induction log was signed by each staff member and retained by the approved centre in the staff file.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.30 Regulation 30: Mental Health Tribunals

(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 process for facilitating patient attendance at Mental Health Tribunals. There was also a Mental Health Act administrator in position in the approved centre.

Training: Staff were trained in relation to the Tribunal process and facilitating patients in attending hearings.

Monitoring of Compliance: The Mental Health Act administrator maintained a log of tribunal dates.

Evidence of Implementation: Tribunals were held in either an MDT room on Steele Unit or a group room in Hampstead Unit. There were copies of the Mental Health Act information booklet for patients available on all the units. There was an independent advocacy service available to patients (SAGE).

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.31 Regulation 31: Complaints Procedure

(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 service had a policy on responding to residents' complaints. The policy identified how a complaint may be made and who handled complaints within the service. Complaints were documented and actions taken.

Training: Staff were aware of the complaints procedures and its application.

Monitoring of Compliance: There was no evidence of annual audit undertaken.

Evidence of Implementation:
Formal complaints were initially reviewed by the line manager and resolved locally. If not satisfactorily resolved, the complaint was escalated upwards to the Director of Nursing and these complaints were recorded on a *pro forma* template.

The complaints policy identified a single nominated person to deal with all complaints (Director of Nursing) and information was posted on the units regarding who was responsible for the handling of complaints. Resident community meeting minutes were recorded and the immediate action taken in response to a complaint was recorded. There was not always a record kept of the outcome or whether the actions were to the satisfaction of the complainant. The approved centre recently engaged in a comprehensive patient satisfaction survey.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.32 Regulation 32: Risk Management Procedure

(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 service had a policy on risk management which covered the requirements of the regulation. In addition, there were policies on absence without leave, suicide and attempted suicide, physical aggression and accidental injury.

Training: Staff were aware of the requirements in completing incident report forms and had received training in risk assessment, Elder abuse (awareness and prevention), CPR and CPI.

Monitoring of Compliance: There were audits completed for identified hazards and risk controls in each unit. Incident reports were completed and audited.

Evidence of Implementation: Each clinical file inspected contained an assessment of risk and a risk management plan. The risk management plan was incorporated into the resident's ICP and was reviewed by the MDT. The service used a number of assessment tools to assess issues such as falls, mobility, risk management, challenging behaviour and tissue viability. The minutes of the Quality and Risk committee were examined and showed clear lines of accountability in the reporting and management of incidents.
One clinical file was inspected of a resident who had previously been absent without leave for a number of hours. There was relevant documentation of the procedures and actions taken and risk re-evaluation. The management of this was well recorded.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.33 Regulation 33: Insurance

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

Inspection Findings

The inspection team was given details of the approved centre's insurance details and an up-to-date confirmation letter of insurance.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.34 Regulation 34: Certificate of Registration

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 Certificate of Registration was up to date, located and clearly displayed at the entrance to all of the units inspected.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Inspection Findings

ECT was not provided in the approved centre and no patient was receiving ECT in another approved centre.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

4.2 Section 69: The Use of Seclusion

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

Inspection Findings

As seclusion was not used in the approved centre, this rule was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

4.3 Section 69: The Use of Mechanical Restraint

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

Inspection Findings

Processes: The approved centre had a written, up-to-date policy on restraint which covered both mechanical and physical restraint. Mechanical means of bodily restraint was used in the approved centre but only in relation to Part 5 of the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, that is *the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others*. There was a policy and processes in place in respect of the management of Part 5 restraint in the approved centre.

Training: Relevant staff were trained with respect to Part 5.

Monitoring of Compliance: The recording process for Part 5 served as a method of monitoring as was the case in respect of the five clinical files seen by the inspection team.

Evidence of Implementation: In the two clinical files inspected on Tuke Unit and the three clinical files inspected on Pinel unit, all of the files showed that the recording requirements for restraint were fully completed. All prescriptions on the use of mechanical restraint had been in consultation with the resident and their families and identified in residents' ICPs.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 Part 4: Consent to Treatment

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

(a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

(b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

(b) where the patient is unable or unwilling to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

(a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

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

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

Inspection Findings

Processes: The approved centre had a process in place covering the provision of consent in relation to the administration of medicine.

Training: Staff were aware of and understood the processes in place for the assessment of capacity and obtaining consent for treatment. No training was documented.

Monitoring of Compliance: Compliance with the requirements in relation to consent were overseen and monitored by the MHA administrator in conjunction with the responsible consultant.

Evidence of Implementation: There was one detained patient in the approved centre. The patient had been in continuous receipt of medication for over three months. The patient had declined to consent to continuous administration of medication. A Form 17(Treatment Without Consent Administration of Medicine for More than 3 Months Involuntary Patient – Adult) was fully completed and the precise medication was recorded.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: The approved centre had a written, up-to-date policy on restraint which covered both mechanical and physical restraint. The policy identified the need for staff to be trained in the use of physical restraint and those who may initiate restraint.

Training: Even though restraint was an uncommon occurrence in the approved centre, relevant staff had received CPI training and this was documented.

Monitoring of Compliance: The service had conducted an audit on the use of physical restraint within the approved centre.

Evidence of Implementation: The clinical file of one resident who had been restrained recently on Steele Unit was examined. There was evidence that physical restraint had been used to prevent injury to self and others and this was not prolonged beyond what was necessary. The order had been initiated by a registered nurse and there was evidence that gender sensitivity was demonstrated. The recording of the physical restraint episode in the clinical practice form for physical restraint was complete and there was evidence of MDT involvement both pre and post restraint.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

6.2 Admission of Children

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

Inspection Findings

As children were not admitted to the approved centre, this regulation was not applicable

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.3 Notification of Deaths and Incident Reporting

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

Inspection Findings

Processes: The service had a policy on the management, reporting and investigation of an incident, serious untoward incident and near miss. The policy outlined the reporting procedures and the notification of deaths requirements and procedures.

Training: Staff were aware of the processes involved in reporting deaths and incidents within the approved centre.

Monitoring of Compliance: Incidents were monitored, reviewed and audited and the quality and risk committee reviewed incidents with a view to quality improvement.

Evidence of Implementation: There was an identified Quality and Risk Manager. There had been 15 deaths of residents in 2015 to date and each had been notified to the MHC as required. A six-monthly summary of incidents was reported to the MHC.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

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

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

Inspection Findings

Processes: There was a policy in place on working with people with an intellectual disability (ID).

Training: Relevant staff had been trained on communicating with a resident with an intellectual disability through the online learning portal. The senior management team informed the inspection team that intellectual disability awareness training had been set up for staff to attend in St. Vincent's, Navan Road, but had yet to commence.

Monitoring of Compliance: There was no evidence presented of any formal audit of processes relating to working with people with ID.

Evidence of Implementation: There was one longstanding resident in the approved centre with an intellectual disability. However, the resident had no liaison or involvement with the disability services. There was an individual care plan in place for the resident, and care and communication were appropriate to the resident's needs.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

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

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

Inspection Findings

No resident in the approved centre was receiving ECT and there were no facilities for providing ECT on site.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.6 Admissions, Transfer and Discharge

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

Inspection Findings

Processes: There was a policy on admission, transfer and discharge. The policy addressed issues including planned admissions, assessment process, internal and external transfer of care and the role of the keyworker in relation to resident discharge coordination and liaison.

Training: Staff were trained commensurate with their role within the approved centre.

Monitoring of Compliance: Admissions and discharge of residents were monitored and audited. Resident experience surveys were used to inform quality improvement.

Evidence of Implementation:
Admission: The inspection team examined clinical files on Hampstead, Steele and Tuke units for the purpose of inspecting for compliance with the code on admission. The files showed that the admissions had been planned with referral letters and pre–admission assessment and liaison. The admission process included medical and nursing assessment, family input and collateral, where consented to, and the development of an initial ICP and risk assessment.

Transfer: No resident was out of the approved centre on transfer. The policy outlined that, in the event of resident transfer, the resident must be escorted by either a healthcare assistant or nurse depending on the resident's needs. The person transferring the resident must ensure medical and nursing transfer letter, list of prescribed medication, including medications taken that day, notification of next of kin and resident's own toiletries and clothing are all transferred with the resident.

Discharge: The clinical file of one resident who had been discharged was inspected. Discharge had been planned with the resident and their family and the resident's ICP supported coping with life post discharge. Day arrangements had been organised with a referral made for home supports for the resident. The OT had organised follow-up with the resident to support independent living. Staff liaised with the family in relation to the discharge date and to make arrangements. A medication prescription was completed and a discharge medical letter was provided to the resident's general practitioner.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		