

Mental Health Commission
Approved Centre Inspection Report
(Mental Health Act 2001)



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| APPROVED CENTRE NAME: | St Edmundsbury Hospital, Lucan, Co. Dublin |
| IDENTIFICATION NUMBER: | AC057 |
| APPROVED CENTRE TYPE: | General Adult |
| REGISTERED PROPRIETOR: | Mr Paul Gilligan |
| REGISTERED PROPRIETOR NOMINEE: | Not applicable |
| MOST RECENT REGISTRATION DATE: | 25 May 2013 |
| NUMBER OF RESIDENTS REGISTERED FOR: | 50 |
| INSPECTION TYPE: | Unannounced |
| INSPECTION DATE: | 5, 6 and 7 October 2015 |
| PREVIOUS INSPECTION DATE: | 25 October 2014 |
| CONDITIONS ATTACHED: | No |
| LEAD INSPECTOR: | Ms Orla O'Neill |
| INSPECTION TEAM: | Mr Donal O'Gorman |
| THE INSPECTOR OF MENTAL HEALTH SERVICES: | Dr Susan Finnerty MCN 009711 (Acting) |

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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

St Edmundsbury Hospital was based in the original house of Edmund Sexton Pery, the Speaker of the Irish House of Commons, which was purchased by St Patrick's Hospital in 1898 and opened first as a convalescent facility in 1899. The original house had been extended and modernised to provide comfortable accommodation for up to 50 in-patient, outpatient and day services. The approved centre was located on 16 acres of parklands and was surrounded by 274 acres of agricultural lands. Lucan village was within a short walking distance. All bedroom accommodation was on the ground floor and was almost exclusively in single en suite rooms. A lift had been installed which provided access to the lower ground floor medical records and provided wheelchair accessibility to clinical and therapeutic services located on the upper floor. The entrance door was unlocked and opened onto a reception hallway. Building work was due to commence to redevelop the reception and admission area.

St Edmundsbury Hospital (SEH) provided care and treatment for voluntary residents only. The approved centre was part of the St Patrick's Mental Health Services (SPMHS). In-patient therapeutic services and programmes were provided both onsite at SEH and also at St Patrick's University Hospital (SPUH). The approved centre provided transport between the two approved centres so that residents could attend both the daytime therapeutic services and also an evening social and recreational programme called the *Twilight Programme* at SPUH. There were 47 residents at the time of the inspection and SEH provided a quiet environment for care and treatment of voluntary residents.

2.2 Governance

St Edmundsbury Hospital, as part of St Patrick's Mental Health Services (SPMHS), was governed by Royal Charter which underpinned its not-for-profit status and philanthropic purpose. The Board of Governors provided their time on a voluntary basis and comprised both appointed and ex officio members. The Board of Governors' governance code was based on the principles of Dean Swift, founder of the SPUH, and by the values of the Mental Health Act 2001, the European Charter of Human Rights and the United Nations Principles for the protection of persons with mental illness and the improvement of mental health care. The Governors had overall responsibility for internal control procedures and for reviewing their effectiveness and the Board invested the running of the hospital in a Senior Management Team. There were clinical and corporate governance structures and processes in place. There was a Carer and Consumer Council. All governance committees met regularly and governance records were provided to the inspection team.

2.3 Inspection scope

This was an unannounced annual inspection and all applicable aspects of the regulations, rules and codes of practice were inspected against.

The inspection was undertaken onsite in the approved centre from:

09:30 – 17:00 on the 5 October 2015

09:00 – 17:00 on the 6 October 2015

09:00 – 16:00 on the 7 October 2015

Ref MHC – FRM – 001- Rev 1

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2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 25 October 2014 found the approved centre to be compliant with all the applicable regulations and codes of practice. There were no outstanding issues or recommendations made.

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 2015 inspection showed that SEH was compliant with all applicable regulations, rules and codes of practice.

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 7 – Clothing |
| Regulation 8 – Residents' Personal Property and Possessions |
| Regulation 9 – Recreational Activities |
| Regulation 10 – Religion |
| Regulation 11 – Visits |
| Regulation 12 - Communication |
| Regulation 13 – Searches |
| Regulation 14 – Care of the Dying |
| Regulation 15 – Individual Care Plan |
| Regulation 16 – Therapeutic Services and Programmes |
| Regulation 18 – Transfer of Residents |
| Regulation 19 – General Health |
| Regulation 20 – Provision of Information to Residents |
| Regulation 21 – Privacy |
| Regulation 22 – Premises |
| Regulation 24 - Health and Safety |
| Regulation 26 - Staffing |
| Regulation 27 – Maintenance of Records |
| Regulation 28 – Register of Residents |
| Regulation 29 – Operating Policies and Procedures |
| Regulation 31 – Complaints Procedures |
| Regulation 32 - Risk Management Procedures |
| Regulation 33 – Insurance |
| Regulation 34 – Certificate of Registration |
| Code of Practice on the Use of Physical restraint in Approved Centres |

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| Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting |
| Code of Practice on Electro-convulsive Therapy |
| Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre |

2.8 Areas of good practice identified on this inspection

- A new clinical room and pharmacy had been developed and residents were able to receive and discuss their medication in private.
- The SEH Service User Information Booklet had been revised and updated in 2015.
- An on-line multi-media resource package about Lithium Therapy had been developed for residents and family. The aim was to support optimum lithium therapy adherence through the provision of information and promotion of knowledge and understanding.
- A sodium valproate information leaflet and clinical guidance document was published for residents, particularly females of childbearing potential, and prescribers.
- A new medical records area had been commissioned at SEH. This facilitated speedy access to clinical records for those residents being readmitted.
- The newly established SEH Information Centre, located in the main hospital building, provided residents with access to Eolas, the SPUH Service User Information portal. The information centre had defined opening hours, staffing and resources.
- The Consumer and Carers Council developed *A Carers and Supporters Information Booklet*. This guide highlighted how to best support a person through their recovery journey, how to stay well oneself and a list of useful resources and organisations for information and support.
- A health and safety awareness initiative entitled *Don't Walk By* was launched aimed at promoting inclusive staff responsibility for the identification and management of risks and the health and safety of residents, visitors and staff. The initiative included tailor-made posters displayed throughout strategic staff locations.
- The Clinical Audit Programme 2015 included: appropriate use of benzodiazepines and hypnotic drugs; monitoring of lithium therapy; appropriateness and effectiveness of antibiotic prescribing practice; the use of the PAS medical record tracking system; use of sodium valproate; the social work screening tool; falls prevention and management; the use of high dose antipsychotic medications.
- A Community Reinforcement Approach and Family Training (CRAFT) initiative had been developed. This eight week cognitive-behavioural programme was aimed at empowering and training family or concerned significant other to live with and help a loved one with addiction, who is either in treatment or resisting treatment.

2.9 Reporting on the National Clinical Guidelines

The approved centre had policies and procedures in place for infection control. An infection control nurse provided input and training to SEH staff. The approved centre operated in accordance with the National Clinical Guidelines and had audited its service according to the Health Information and Quality Authorities (HIQA) standards for infection control and with good outcomes achieved.

2.10 Resident Interviews

The inspection team spoke with residents in the dining room during lunch service and also met with three residents on an individual basis. The residents spoken with expressed positive satisfaction with their care and treatment and with the hospital environment and meals provided. The residents spoke highly of their access to a key worker and the regularity with which they met their treating consultant psychiatrist and team. The residents were fully informed about and actively contributed to their care plans. One resident stated that staff were supportive and non-judgemental and that there was a sense of staff belief and optimism in each resident's recovery process. One resident expressed their appreciation for being able to be discharged home with the option of pursuing a specific treatment programme at a later date as an outpatient. Three residents commented positively about the governance and leadership evident in the running of SEH and stated that this filtered down to all departments and that care and treatment was seamless.

2.11 Feedback Meeting

The inspectors met with senior managers at the end of the inspection visit. The aim of this meeting was to provide preliminary feedback on the inspection findings and to provide an opportunity for clarification and discussion of any issues related to the inspection and for comment and feedback from the approved centre staff. A broad range of senior managers attended including: the Chief Executive, the Clinical Director, the Deputy Clinical Director, a Consultant Psychiatrist, the Director of Services, the Director of Nursing and Nursing Managers, the Heads of Discipline for Clinical Psychology, Occupational Therapy and Social Work, the Director of Human Resources, the Director of Finance, the Director of ICT, Business Development and Data Protection, Programme Managers, the Senior Administrator Clinical Governance and Mental Health Act and the Nurse Practice Development Coordinator. There were no issues arising from the inspection visit. The SPUH management team expressed their endorsement of the MHC judgement support framework for in-patient mental health services which they viewed as an aid to quality improvement. SEH had embarked on a programme of policy review and audits linked to the judgement support framework.

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 defined process in place to ensure the identification of residents prior to the administration of medicines, healthcare or treatments. Two identifiers were used: photographic identification, medical record number (MRN), date of birth and address. Where residents had the same or similar names, a red highlighter sticker stating “Caution – similar named patient” was affixed to all records. Residents provided written consent to photographic identification. The resident information booklet stated that no digital image of the resident was held once the photograph had been printed for the clinical records.

Training: Staff interviewed were cognisant of the policy and procedures for resident identification. New staff were verbally inducted in the process by the person in charge or their line manager and provided with access to all policies and procedures and web-based resources.

Monitoring of Compliance: The approved centre had completed an audit of compliance with this regulation. Compliance was monitored and quality initiatives were implemented. There were no incident reports for a breach of this regulation.

Evidence of Implementation: Forty-seven individual clinical files and a sample of medication prescription and administration records were inspected. Each contained photographic identification, medical record number, date of birth and address. Where a resident did not consent to photographic identification, this was documented. Residents had signed consent to photographs being taken and used for this purpose. Residents were informed about the purpose and process for ensuring their accurate identification for all healthcare processes. The admitting nurse verbally explained the process to a resident and the service user information booklet explained this also.

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: There were written operational policies and procedures for residents' meals and nutritional wellbeing. A catering company was contracted to provide all meals which were freshly cooked on-site. A catering organisational chart showed clear lines of accountability for the provision of meals. There were procedures in place to provide special diets, dietetic assessment and input and for providing residents with adequate meal choices and nutritional guidelines. There was a defined nutritional screening procedure and process to monitor nutritional health and wellbeing.

Training: Staff were cognisant of the policies and procedures for assessing and monitoring residents' nutritional needs and physical health. Staff were trained commensurate with their roles in the provision of food, including special diets, and in supporting nutritional health.

Monitoring of Compliance: Audits had been completed to determine compliance with this regulation. Nutritional assessment was completed as part of the nursing admission process and was monitored by the treating team. The Service User Satisfaction Survey specifically enquired about residents' satisfaction with food and service in the dining room. The results were analysed and there was a quality improvement process in place. No incidents had been recorded for a breach of this regulation.

Evidence of Implementation: Residents were provided with a choice of three main courses for lunch and tea and also a salad option. Residents made their meal choice at the hot counter. The menu was colourfully printed and posted up outside the dining room and at the servery counter and provided residents with colour-coded nutritional information in a user friendly style. Special food orders and special diet orders could be ordered and nursing staff completed a pro forma diet/meal order form and liaised with catering staff. Coeliac, diabetic and low fat diets were readily available. Religious and cultural dietary needs were catered for also. There was a dietician in the SPUH service who provided input to menus and individual residents as required. The pharmacist also provided guidance on foodstuffs and medications.

Meals were freshly prepared and cooked and presented in an attractive manner. Residents stated that the quality of food was good and there was plenty of choice with adequate portions. Residents could access hot drinks from a drinks dispenser outside of meal times. There were water coolers and a supply of drinking cups throughout the approved centre.

The nursing admission assessment recorded in the clinical files included: weight, height, body mass index, recent changes in body weight or eating patterns, special dietary requirements (e.g. kosher, halal, vegetarian), therapeutic dietary requirements (e.g. low salt, low fat, dairy or gluten free), dysphagia and eating disorder. A validated nutritional tool was being used to assess nutritional needs. Where diet and nutrition were identified as needs for an individual resident, this was recorded in the individual care plan and monitored by the multi-disciplinary team (MDT).

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: Both the approved centre and the contracted catering company had policies and procedures in place to meet the food safety legislative requirements and standards. There were defined resources and facilities, roles and responsibilities for all aspects of food safety within the approved centre.

Training: Staff were trained appropriate to their roles and responsibilities. The catering staff were trained in food safety and hygiene.

Monitoring of Compliance: The contracted catering company monitored and reviewed their food safety policies and procedures annually as part of their certified quality management system. The approved centre audited and monitored other aspects of food safety and analysis was completed to identify quality improvements.

Evidence of Implementation: There were sufficient and adequately trained catering and ancillary staff employed to deliver a safe food management system. The catering staff measured and recorded food and equipment temperatures and these were audited. The records were available to the inspection team and were up to date. The Environmental Health Officer's report of the 06 March 2015, the twice-yearly water testing results and the microbiological food test reports were also provided to the inspection team and there were no outstanding issues. The kitchen facilities, trolley and hot counter were all stainless steel and provided separate storage, preparation, cooking and serving areas. The approved centre managed waste in accordance with legislative requirements and environmental best practice. There was a cleaning and environmental monitoring schedule and tasks were signed off as completed with ongoing monitoring. Catering staff had separate hand washing, lavatory and changing facilities. Catering staff were observed wearing personal protective clothing while working. Residents were surveyed about their experience of cleanliness.

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 were policies and procedures about residents' clothing, including the wearing of day and night clothes, storage and safekeeping, laundry facilities and emergency clothing. The roles and responsibilities of staff and residents were clearly stated.

Training: Staff were cognisant of the policies and procedures in relation to resident clothing.

Monitoring of Compliance: Where a resident was required to wear night clothes as part of their individual care plan, this was recorded in the clinical record and reviewed by the MDT. Where an incident or complaint arose in relation to clothing, this would be recorded in the incident report book and reviewed by the management team with a view to quality improvement. There was no evidence of annual audit for this regulation.

Evidence of Implementation: The inspection team reviewed related policies and documentation, spoke with staff and looked at storage facilities for residents' clothing.

The admitting nurse completed a property checklist for each resident being admitted. This included a record of personal clothing. Residents were informed about what clothing would be useful and appropriate while in-patient in the approved centre and about the laundry arrangements. An external laundry company provided a twice-weekly pick-up and return personal laundry service for residents. Residents paid directly for this service. Each resident had their own lockable wardrobe and there was additional storage if required. No resident was required to wear night clothing as part of their care plan. The housekeeping department maintained a supply of emergency clothing (day and night attire), in the event that a resident required such, and this could be accessed 24 hours a day. The finance department provided funding to maintain the repository stock of emergency clothing. The social work department facilitated resident access to funding where a resident wished to purchase their own clothing while in hospital.

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 policies and procedures for the recording, storage and management of residents' personal property and possessions. The roles and responsibilities of staff and the individual resident were clearly outlined.

Training: Staff were cognisant of the policies and procedures for the management of residents' personal property and possessions.

Monitoring of Compliance: Monitoring consisted of a property checklist which was recorded at the time of admission and updated as required. Incident reports were completed where an incident arose in relation to a resident's property. Such incidents were reviewed by the management team with a view to quality improvement. There was no evidence of annual audit for this regulation.

Evidence of Implementation: Each clinical file inspected contained a counter-signed property checklist. The admitting nurse informed residents about the arrangements for the storage and management of their personal effects while in-patient in the approved centre. The service user information booklet also outlined these arrangements. Residents were encouraged to send property home with relatives and to retain essentials for their hospital stay. There was safe storage provided.

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 were policies and procedures in place for recreational provision, including, physical, educational, creative and social recreation. Staff roles and resources were clearly defined. The *Twilight Programme* provided recreational programmes out of hours and at weekends.

Training: Staff were cognisant of the policies and procedures for recreational provision. Staff providing recreational activities were appropriately trained. The Human Resource Department ensured that all persons providing recreational activities had completed an induction programme prior to commencing activities.

Monitoring of Compliance: Resident uptake and participation in recreational activities was recorded and audited on an annual basis. Residents completed a satisfaction questionnaire. The Twilight team and the Programme Manager analysed this data for the purpose of quality improvement and service development.

Evidence of Implementation: There were ample sitting rooms and communal spaces for residents to engage in recreational activities. Board games, newspapers, magazines and books, televisions and DVD players, electronic games console, radio and music players and arts and crafts materials were available. There was a snooker table, table tennis and gym equipment in a large room overlooking the River Liffey and woodlands. The extensive woodlands and landscaped gardens provided an opportunity for walks and fresh air. Residents were provided with high visibility vests for walking outdoors as there was no separate footpath on the driveway. The *Twilight Programme* provided activities in SEH on Wednesday evenings. However, residents could attend Twilight activities in SPUH also. A colourful timetable of Twilight activities was posted up. The timetable varied from week to week based on resident feedback. Twilight activities included music sessions and performances, creative writing, art and creative activities, guided meditation, Tai-chi, Yoga, quizzes and movie nights. Family and visitors were welcome to participate in some Twilight activities if a resident wished. Inspection of the clinical files showed that residents were risk assessed in relation to participation in recreational activities. Medical referral for physical recreation activities was required where the resident had an identified physical condition or where clinical staff considered medical review was indicated.

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 and procedures in relation to facilitating residents in their religious or spiritual practice while in the approved centre. The scope of the policies included respect and facilitation of religious or spiritual values and beliefs during the provision of healthcare in the approved centre. There was a multi-denominational oratory for religious and ecumenical events.

Training: Staff were cognisant of the policies and procedures in relation to religion. The Human Resource department managed the arrangements for religious ministers providing services to residents and required chaplains/ministers to be authorised and licenced by their respective diocesan authority.

Monitoring of Compliance: There were no incident reports showing a breach in relation to this regulation. There was no evidence of annual audit in relation to this regulation.

Evidence of Implementation: The oratory was open and signposted. A Roman Catholic priest celebrated mass for residents each week. Ecumenical services were held on occasion. The clinical files inspected showed that religion was recorded at the time of admission. Residents were asked at this time if they wished to be approached by chaplaincy services or if they would prefer not and this was recorded. If a resident had dietary or specific healthcare preferences based on religion this was also recorded. At the time of inspection, no resident required to be specially facilitated in this regard.

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: SEH operated an open visiting policy in recognition of the importance of contact with family and friends. The policy identified the reasons where visiting might be restricted in the best interests of the resident. The policy addressed the procedures for managing visitors, including: identification of visitors, visiting times and facilities, children visitors, resident or family request for refusal of visitation and circumstances where the approved centre might refuse a visitation. Staff roles and responsibilities were outlined.

Training: Staff were aware of the policy and procedures for visits. Staff were trained in the protection of vulnerable adults and children.

Monitoring of Compliance: Residents' individual visiting requirements were recorded and monitored. There was no indication that there had been any incident or breach in relation to this regulation. An audit had been completed on visits in 2015.

Evidence of Implementation: Visiting times were clearly displayed. However, the nurse in charge used discretion in relation to flexibility on visits. At the time of inspection, there were no restrictions on visits. Residents met visitors in their rooms or in communal sitting rooms and spaces. There was a family therapy room available for visits also.

SPUH had developed a *Charter of Service User and Family Rights and Responsibilities St Edmundsbury Hospital* and this document included guidance on visits. There was a leaflet entitled *Support and Information for Parents and Guardians* which was aimed at supporting and educating a resident or family in the event of their child visiting them in hospital. Child visitors were required to be accompanied by a responsible adult at all times. There was also a leaflet entitled *Carers and Supporters Information Guide* which had been developed in consultation with the Consumer and Carers' Council SPUH. This guide aimed to support family visitors and carers. The health and safety policy included the safety of visitors and children.

The admission assessment record and, if applicable, the individual care plan specified resident needs in relation to visits. Where specific needs were identified in relation to visitors, this was incorporated into the ICP and the nursing staff monitored visits and MDT reviewed outcomes. Nursing staff, with a resident's written consent, engaged with family visitors and provided support or education, and enquired how visits had gone.

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 were policies and procedures about residents' rights and access to and use of communications. These included the identification of a resident's communication needs such as requirement for interpretation or signing services and/or plain English information; postal services; fax; email access; internet and web browsing; and telephone. The facilities and staff roles and responsibilities in facilitating communication were outlined in the policy. The criteria and procedures for restricting communication in the best interests of a resident or others was detailed in the policy.

Training: Staff were aware of the policies and procedures in relation to communication.

Monitoring of Compliance: A resident's communication needs were assessed at the time of admission and reviewed by the MDT. There was no evidence of annual audit in relation to this regulation. Any incidents or complaints related to communication were reviewed by the management team. There were no incidents recorded.

Evidence of Implementation: Residents retained their mobile phones and chargers unless risk assessment indicated otherwise. Where retaining a personal mobile phone was risk assessed as being detrimental to a resident's health and wellbeing, this was discussed with the resident and written in the individual care plan. All residents retained their mobile phones at the time of inspection. Residents commented positively to the inspection team about the experience of having their phones at all times and ease of staying in touch with family and friends. There was a daily postal service for residents. Residents could send and receive post via reception and An Post collected post Monday to Friday. Residents had access to a fax machine on request. Residents could retain and use their own laptop computers. Residents had the use of a computer located in the main hallway and could access email and the SPUH service user intranet site. Residents could access a number of websites but a filter system operated to ensure appropriate usage.

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 and procedures for the carrying out of searches with and without consent and on the finding of illicit substances. Staff roles and responsibilities were clearly defined. There were defined processes to obtain a resident's written consent and this was required to be recorded in the clinical file. The process for informing residents about searches, for communicating with the resident throughout the course of a search and for recording searches were specified in the policy.

Staff reported that searches were an infrequent practice and any decision to search would be based on risk assessment. The policy required two staff members to be present at all times during the course of a search, for one to be a registered nurse and for gender sensitivity to be applied. The policy and procedures met the standard specified in this regulation.

Training: Staff were aware of the policies and procedures for searches. A consumer council member and a social worker had provided additional training to all staff on dignity and respect.

Monitoring of Compliance: The policy required searches to be recorded in the individual clinical files and documented in the individual care plans (ICP) which were reviewed by the treating team. Annual audits were not completed for searches.

Evidence of Implementation: No searches had been conducted in relation to current residents.

The compliance rating for this regulation is based on policies and procedures and training.

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 suite of policies about the care of a dying resident, advance healthcare decisions and procedures in the event of a death. The approved centre did not adopt Do Not Attempt Resuscitation (DNAR) orders. However, the expressed wishes of a resident in terms of not resuscitating were required to be recorded and discussed with the Medical Director. The policy specified staff roles and responsibilities and the scope of care to meet the religious, social, cultural, psychological, emotional and physical needs of the resident. The policy also addressed the process to meet the needs of relatives. The death notification and reporting requirements were outlined in the policy.

Training: Staff were aware of the policies and procedures related to this regulation.

Monitoring of Compliance: Individual care, including end of life care, was recorded in the individual care plan (ICP) and was monitored and reviewed by the multidisciplinary team (MDT). Incident reports were completed and the MHC was notified where a death occurred.

Evidence of Implementation: The deaths of two residents had occurred in 2015 to the date of inspection. One resident was on leave and one resident was absent without leave at the time of death. The approved centre notified the MHC of these deaths within the defined 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 policy on individual care planning. The policy detailed the arrangements for the preliminary care plan which was drawn up at admission and the subsequent review and development of an individual care plan (ICP) by the multi-disciplinary team (MDT). The policy clearly stated the issues to be considered and evaluated by the MDT in care planning, the role of the key worker, the procedure to elicit a resident's goals and expectations and the requirement to incorporate discharge planning from the outset. The policy required staff to include family or carer in discussions where a resident consented to such communication. The approved centre used a pro forma document to record the ICP.

Training: All clinical staff were trained in the ICP process and documentation. ICPs were scheduled in the induction training process for staff and training was signed off by the head of discipline.

Monitoring of Compliance: The ICPs were regularly audited and the results were communicated to all relevant staff and reviewed in the clinical governance meetings. The audits were comprehensive and looked at 22 fields of data. The audits placed the resident's experience of the ICP at the centre of the process and were used to inform quality improvement initiatives. No incidents had been recorded for a breach of this regulation.

Evidence of Implementation: The clinical files of 47 residents were inspected. Each resident had an ICP which was well completed and provided a detailed account of: the resident's expectations; the treatment goals, interventions and timeframes; which staff member was charged with providing each aspect of care and treatment; the review and outcomes achieved; and discharge plans. The ICPs were reviewed each week by the MDT. One of the inspectors attended an MDT meeting and observed the process of ICP development and reviews. The process was observed to be fully interdisciplinary with each discipline contributing to discussion and evaluation of the physical and psychosocial goals, treatments and outcomes. The domains of care and the treatments provided were comprehensive in their scope and showed meaningful consideration of the resident's life context on discharge. Where a resident had provided consent, family input and collateral were key components in the ICP process. The MDT involved in this process comprised: consultant psychiatrist; two non-consultant hospital doctors; a clinical nurse manager and a staff nurse; two clinical psychologists; a pharmacist; a family therapist; two occupational therapists; a clinical nurse specialist and a social worker. The discussion showed that all the MDT were knowledgeable about the resident and gave due consideration to the resident's views and preferences. The inspection team met with three residents, each of whom was fully informed about their ICP and their personal discharge pathway.

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 *In-patient Therapeutic Programmes St Edmundsbury* and there was also a suite of policies outlining the other therapies provided. These policies laid out the referrals procedures, the inclusion and exclusion criteria for therapeutic programmes, the governance structures and processes for therapeutic services and programmes, the staffing and facilities provided and the outcome measurement and review process.

Therapeutic programmes were managed by the programme coordinator under the line management of the director of nursing and the director of services. Three consultant psychiatrists, designated by the clinical director, provided clinical lead input to programmes at SEH. Written material such as booklets and therapy manuals were distributed to educate and inform residents and their families about the therapeutic programmes specified in their ICP. This information material was approved through the governance process in place for therapeutic services and programmes. There was an In-patient Programme Review Committee.

Training: Staff were aware of the policies and procedures for therapeutic services and programmes. Staff delivering therapeutic services and programmes were trained appropriate to their role.

Monitoring of Compliance: Audits were completed in relation to all therapeutic services and programmes. Initial assessment and outcome measures and service user feedback were recorded for the purpose of evaluating the effectiveness of therapeutic provision. The In-patient Programme Review Committee monitored and reviewed therapeutic services and quality improvement was a key focus. No incidents reports had been completed to indicate any breach of this regulation.

Evidence of Implementation: Forty-seven ICPs were inspected and each ICP specified the therapeutic requirements for the individual resident concerned. The clinical progress records and the ICP reviews showed that therapeutic services and programmes had been provided in accordance with assessed needs and that outcomes were evaluated on an individual basis. The approved centre had clear inclusion and exclusion criteria for residents being referred to various programmes. The MDT reviewed therapeutic needs and provided each resident with an explanation about the therapeutic programmes they were required to attend. Each discipline and programme provider made a record in the clinical file of the resident's participation, engagement and outcomes for the groups or individual therapy sessions attended. Inspection of the individual clinical files evidenced a clear recovery-oriented therapeutic care pathway with well documented progress notes. The benefits of the provision of therapeutic programmes informed by outcome measurement and ongoing review were evident in the progress notes in the individual clinical files. The records showed residents were achieving corresponding improvements and health gains associated with therapies and treatments provided.

The therapeutic programmes were structured around core themes with a number of treatment programmes or options provided under each heading. The programme pillars included: addiction and dual diagnosis; bipolar disorder; anxiety disorders; depression recovery services; eating disorders services; psychology programmes; recovery programmes; mindfulness; and other programmes such as psychosis recovery, healthy self-esteem, wellbeing programmes and medication awareness groups. Therapeutic programmes were provided by clinical psychology, occupational therapy, social work, cognitive behaviour therapy, family therapy, psychotherapy, nursing (including clinical nurse specialists), physiotherapy, pharmacy and medical staff. Each discipline provided inputs within the scope of their practice.

One resident interviewed said that the treatment and therapy provided to them in SEH had been “seamless” and “led from the top”. The reported experience resonated with the processes in place for this regulation.

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

Children were not admitted to SEH and 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 roles and responsibilities and the information required to be transferred with the resident.

Training: Staff were aware of the policy and procedures operating in relation to the transfer of residents. Staff signed the policy log to this effect.

Monitoring: The transfer of residents was monitored and audited.

Implementation: No current resident had been transferred to another hospital or approved centre.

The evaluation of compliance for this regulation was based on the policy and procedures in place for the transfer of a resident and the information required to be sent to the receiving approved centre or hospital.

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: A number of policies addressed physical assessment and general health management in SEH. These included the processes and procedures operating for the management of a medical emergency, access to national health screening programmes, national clinical guidelines, physical examinations and tests, and the promotion of health and wellbeing. There were defined resources in place such as clinical rooms and emergency medical equipment and drugs.

Training: Staff were aware of the policies and procedures and of their own roles and responsibilities. Staff training in basic life support and in medical emergencies was up to date.

Monitoring of Compliance: Each resident was physically examined at the time of admission and issues arising were incorporated into the ICP. The MDT monitored and reviewed ICPs weekly. There was no evidence provided of annual audits in relation to this regulation.

Evidence of Implementation: Forty-seven clinical files were inspected. Each resident was physically examined at the time of admission and this was recorded on a pro forma assessment document. Each resident had an ICP and physical needs were included in the care plan as applicable and were reviewed by the MDT on a weekly basis. There were clinical rooms where physical examinations or procedures were carried out in privacy. No resident had been in SEH for a period in excess of six months and, therefore, the requirement to have a six-monthly physical examination was not applicable. Residents had access to national screening programmes such as breast check, cervical screening, and retinal and bowel checks. A new primary care centre had been established at SPUH and the service was available for residents.

A programme entitled *Links to Wellbeing* had been developed and was available to residents of SEH. The programme was designed for all service users who were on chronic psychotropic medication, had a sedentary lifestyle and who were at risk of developing or had metabolic risk factors.

There were dietetics therapeutic groups run at SPUH which were available to residents. The groups included a weight management group, a healthy heart group and a diabetes impaired glucose tolerance group.

The physical health service provided to residents included: strategic physical health monitoring from the start of treatment; promotion of healthy eating habits; promotions of physical exercise and healthy life style; promotion of day-to-day communication and dysphagia risk assessments; falls risk assessments; promotion of self-efficacy and quality

of life and health education. The clinical files contained evidence of physical health monitoring such as records of X-ray results, Magnetic Resonance Imaging (MRI) and Computerised Tomography (CT) scan results, blood test results and reports from tertiary medical services.

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: The approved centre had a suite of policies about the provision of information to residents and their families, about plain English, literacy friendly and accessible information formats, about interpretation services and about resident access to the SPUH resident information portal entitled *Eolas*. There was an information booklet about St Edmundsbury Hospital. The information resources included designated staff and information centres.

Training: Staff were aware of the policy and procedures for the provision of information to residents and families.

Monitoring of Compliance: The provision of information to residents was monitored and audited. The Manager of the Information Centre monitored and audited resident visits and requests for information.

Evidence of Implementation: There was a 36-page information booklet for residents about their hospital stay in SEH. Details provided included care and treatment, therapies, ICP and MDT, advocacy, rights and responsibilities, complaints, visiting arrangements, family and carer supports, communication arrangements, discharge planning and post discharge supports and service user satisfaction surveys. Each resident was provided with an information folder on admission. The information leaflets on diagnoses, treatment programmes, medications and support services were printed to a high quality. The Information Centre contained a library of useful books and DVDs on mental health. Residents could complete an information request form if particular information was required and the Information Centre staff and volunteers would source and provide the information. Voluntary and self-help groups provided education and support sessions in the information centre and contributed alongside staff to the morning lecture series for residents.

Compliance Rating:

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

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: The approved centre had a range of policies and procedures in place to ensure residents were treated with dignity and respect at all times. These included processes to ensure modesty was protected; residents remained autonomous and independent, wherever possible; resident information was shared solely in line with confidentiality policies; residents were cared for in an appropriate environment; residents had their preferences taken into account; residents could appoint a representative to assist with or make healthcare decisions on their behalf; and resident privacy in personal relationships and in communications. The policies outlined staff roles and responsibilities. There was a Service User and Family/Carer Charter which informed residents and families what their rights and responsibilities were in relation to healthcare delivery and SEH.

Training: Staff were cognisant of the policies and procedures for ensuring privacy. There was a structured staff induction programme and heads of discipline or department were responsible for ensuring staff were aware of the processes to uphold privacy and dignity. Additional staff training in dignity and respect had been provided by a social worker and a member of the Consumer Council.

Monitoring of Compliance: An annual audit was conducted to determine compliance that residents had been informed of their rights and responsibilities. Incidents were recorded for non-compliance and, if staff were involved, the incident would be processed through the allegations against staff investigation process. Residents completed a satisfaction survey and opportunities for improvement were reviewed on an annual basis. There were no recorded incidents in relation to breach of privacy.

Evidence of Implementation: The premises provided an environment where resident privacy could be assured during the receipt of healthcare. There was a clinical room for healthcare examinations and procedures. Medication was administered in the pharmacy room and this enabled residents to receive medications in private. There were three shared bedrooms and the rest of the accommodation was in single en suite rooms. Each resident had either a single bedroom or, if sharing, there were privacy curtains around each bed. Showers and toilets were all lockable. Interview and group therapy rooms afforded privacy. There was no confidential information on display and all clinical files were securely stored. The inspection team observed staff interacting with residents in a caring and respectful manner and addressing residents by their preferred form of address. Residents' preferred form of address was recorded in the individual clinical files at the time of admission. Residents stated that staff knocked on their bedroom doors before entering and were always courteous and respectful.

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 policies and procedures in place for the management, maintenance and development of the premises. Staff roles and responsibilities were identified and included a facilities manager.

Training: Staff were aware of the policies and procedures for the maintenance and management of the premises commensurate with their roles.

Monitoring of Compliance: There was ongoing monitoring and auditing of the cleanliness and infection control practices, safety, upkeep and maintenance of the premises. Quality improvement was an integral task for the relevant management committees and the senior management team.

Evidence of Implementation: The premises was clean, attractively decorated and well maintained. Accommodation was in en suite single rooms and three shared bedrooms. There were ample communal and recreational spaces. The furniture and fittings were modern, well designed and appropriate to the needs of residents. Attention had been paid to the choice and placement of pictures and art work throughout the building. The grounds were landscaped and well maintained and provided seating areas for residents and the opportunity for walks in the woodlands. The immediate garden space accessible directly from the ward area provided a pleasant space to sit and relax. The building was wheelchair accessible throughout. There was evidence of a programme of ongoing upkeep and maintenance. The maintenance request orders were inspected and the process was well managed. Planned work to redevelop the reception area was due to commence the week after the inspection visit. The aim was to provide a more user-friendly and comfortable reception and admission area.

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: There were clear and detailed operational policies and procedures on the ordering, storing, prescribing and administration of medications. The roles and responsibilities of medical, nursing and pharmacy staff were specified in the policies. Policies addressed procedures for medication reconciliation on admission, transfer and discharge; medication reviews; medication errors; the management of the emergency medications and controlled drugs; and the disposal of drugs. The approved centre had the services of a full-time pharmacist to oversee and advise in relation to procedure and practice.

Training: Staff were trained in the required policy and procedures involved in the safe and legal administration of medicines.

Monitoring of Compliance: There was an active programme of monitoring and auditing of medicines. The pharmacist monitored stock and the medication prescription and administration records. The audit reports were reviewed by clinical leads and the clinical governance committee and informed quality improvement processes. Incident reports were completed for any medication mishap or error.

Evidence of Implementation: Documentation and observation confirmed that medication administration was overseen by two appropriately qualified staff. At least two resident identifiers were used in the administration process. Medications, including requirements under the Misuse of Drugs Act (MDA), were appropriately stored and accounted for. Prescription and administration of medication was recorded on an individual medication record. Doctors recorded their Medical Council Registration Number (MRN) on individual prescriptions. Any medication refusals were documented on the medicine administration record. Prescriptions were clearly written with the generic drug name recorded in capital letters. Five prescription records did not contain a discontinuation date. Medications requiring refrigeration were stored in a temperature-controlled fridge which was monitored daily. There was a new clinical and pharmacy room and medication storage and administration areas were adequately maintained and cleaned. The pharmacist attended the MDT meeting.

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 an up-to-date Health and Safety Statement for SEH and a suite of policies addressing health and safety issues in detail. The statement clearly identified the persons with overall responsibility for health and safety and those with designated responsibility for specific aspects. Identified hazards were risk-rated and controls put in place. There was an emergency plan in place. There was a designated health and safety officer and health and safety representatives for the approved centre. There was an occupational health and employee assistance programme in place. The approved centre had governance structures and processes for: risk and patient safety; health and safety; infection prevention and control; environmental health; and the risk register.

Training: Staff were appropriately trained commensurate with their roles in relation to health and safety. Staff were trained in manual handling, hand washing, infection control, fire safety, the management of sharps and clinical waste disposal, personal safety, first aid and the prevention of slips, trips and falls. Staff were trained in reporting incidents and in the inspection and investigation of safety incidents. Staff were also trained in crisis prevention and the management of potential or actual aggression.

Monitoring of Compliance: There was evidence of extensive health and safety audits and the ongoing monitoring of safety. There were scheduled audits of infection control measures, cleanliness, equipment, water, waste management and the environment within the approved centre.

Evidence of Implementation: The health and safety statement for the approved centre had been reviewed annually and was available to staff. The health and safety policy and statement included residents, visitors and staff. The risk register was up to date. Hazards had been risk-rated and controls identified. The fire safety procedures were clearly displayed. The fire reports and staff fire training were up to date and fire drills had been completed. The approved centre had an emergency plan and a full evacuation exercise had been completed in 2015. The infection control nurse had input to the approved centre which included training and consultation in relation to infection control. Antibacterial hand wash dispensers were provided throughout the approved centre. There were separate washroom facilities for staff. Staff were observed to wear personal protective clothing when engaging in food management, cleaning and clinical procedures. There was an occupational health service, a vaccination programme and an employee assistance programme provided for staff. The approved centre had implemented a *Think Safety, Act Safely* programme for staff in 2015.

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

CCTV was used in public areas only, such as the grounds and the entrance hallway and was well sign-posted. 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 |

3.26 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: There were policies and procedures for the recruitment, selection, vetting, appointment and retention of staff. There was a Director of Human Resources who oversaw all aspects of personnel management, including volunteers. There was an organisational chart with clear line management systems in place. There were defined procedures in place for the induction and training of staff and staff wellbeing and welfare. There were defined procedures in place for manpower planning to ensure the range, skill-mix, seniority and numbers of staff were appropriate to the needs of residents.

Training: Staff were fully informed about the policies and procedures related to this regulation. Staff were trained in accordance with their roles and responsibilities for the management and supervision of staff. There was a structured induction programme in place and recorded for all staff and for volunteers.

Monitoring of Compliance: Staffing requirements and provision were monitored on a daily basis and audited regularly. The training schedule and provision was monitored and audited. Incident forms were completed as appropriate for any incident related to this regulation.

Evidence of Implementation: There was an appropriately qualified person in charge of the approved centre at all times. Residents had access to a range and number of qualified professionals adequate to meet their assessed needs and to the layout of the approved centre. There was a Director of Nursing, a Clinical Nurse Manager and four to five Registered Psychiatric Nurses (RPNs) on duty during the day and three RPNs and a shared Assistant Director of Nursing on duty at night. The staffing schedule and duty roster was provided for inspection.

There was an organisational chart for SEH which showed well developed management and governance structures. Three human resource staff files were inspected. These files were well organised and evidenced a robust HR function in operation. Each file contained evidence of curriculum vitae, Garda vetting, references, professional qualification and registration where appropriate, identification verification, pre-employment health screening, contract of employment and performance management and personal development plan. The human resource department was responsible for staff planning and staff welfare and

supported the induction programme and occupational health service available to staff, including annual vaccinations. There was an active programme of continuing professional development and education. This programme was linked to resource requirements and identified best practice in the provision of programmes and services.

Staff training, both mandatory and elective, was up to date. Training included the Mental Health Act 2001 and a copy of this legislation and associated regulations, rules and codes of practice were available for staff both on the intranet and in the nursing office.

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: There were policies and procedures for the creation of, access to, retention and destruction of records. There was a standard operating procedure for making clinical entries and the use of a signature bank and approved abbreviations. There was a defined system for the safe storage of both current and noncurrent clinical records. There were defined procedures for the updating and retention of records related to fire safety, food safety and health and safety.

Training: Staff were aware of the policies and procedures relating to this regulation. There was no evidence of defined or scheduled training in records.

Monitoring of Compliance: The Clinical Governance Committee had commissioned an audit of the Patient Administration System (PAS) and tracking of records in 2015. The results informed quality initiatives, including additional training. Incident reports were completed as appropriate, for example, if there was delayed access to a resident's clinical file. The head of the appropriate department maintained and monitored the requisite records for health and safety records.

Evidence of Implementation: The clinical files were well maintained and contained resident identifiers on each page. Entries from all members of the MDT were contained in this integrated clinical file and were recorded contemporaneously. Entries were legible, clearly signed with date and time of entry. The information recorded was accessible and met good practice standards. A new clinical records storage facility had been developed onsite so as to ensure prompt access to the clinical records of any resident being admitted who had previously been treated in the approved centre. The clinical files of current residents were securely stored in the nursing office.

The records for food safety, fire inspections and health and safety were up to date and provided 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 approved centre maintained a Register of Residents which met the standard of 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 were policies and procedures about the development, approval, communication and review of policies. A process map provided a clear account of this process and the timelines for review.

Training: Staff were aware of the policy and procedures relating to policies. The induction programme made provision for staff to be apprised of all policies and to sign to indicate having read and understood the policies.

Monitoring of Compliance: Policies were monitored by the relevant governance committee with the senior management team having overall responsibility. Policies had been reviewed at a minimum of every three years.

Evidence of Implementation: The policies and procedures were all in date and had been signed by the appropriate approvers. Each policy followed a standardised format and was clearly laid out with headings, cross referenced to other policies and relevant legislation, and each page was numbered. An index of policies was maintained and review dates were flagged in advance. Policies were available online to staff and to the public.

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

The approved centre only admitted voluntary residents and 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 |

3.31 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: There was a defined process for residents to make a complaint or to comment or express an opinion about their experience or observations on SEH and also for the investigation and management of any complaint. The process for informing residents about the complaints procedures was outlined in the SEH information booklet, on posters displayed throughout the approved centre and on the SPUH information website and portal which was available onsite.

Staff roles and responsibilities were outlined in the policy and procedures. The nurse in charge was the identified person to receive complaints in the first instance. Residents could also make complaints in writing or by email and the procedure for doing this was included in the information booklet. The Programme Manager for clinical services had responsibility for the management, coordination and overview of redress for complaints. Depending on the nature of the complaint, the appropriate senior manager was assigned with responsibility for carrying out an investigation, communicating their findings to the complainant and identifying actions required following the investigation. The policy addressed the management and access to records relating to any complaints made.

Training: Staff were aware of the policies and procedures relating to complaints. The induction programme addressed this process and the roles and responsibilities of staff.

Monitoring of Compliance: Complaints were monitored and audited.

Evidence of Implementation: The complaints procedure was documented in the approved centre's information booklet and posters displaying the complaints procedure were displayed on noticeboards.

There were comment cards available in a stand at the main reception area. Comments could be posted in the comment box which was opened daily and the contents were securely delivered to the clinical governance department. The clinical governance staff assigned the task of reviewing and following up on comments to the relevant heads of departments. All complaints and comments were entered on a database. This complaints record was provided for inspection and provided a full account of the complaint, the immediate response and investigation or follow up, the action or resolution and whether the outcome was satisfactory to the complainant. The record indicated that all complaints, including minor and more informal and more significant complaints, were all treated with the same respect and due diligence. The senior management team reviewed the complaints record. There was a procedure for escalating complaints and for referral to an external agency if indicated. There was an advocacy service available for residents.

Compliance Rating:

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

3.32 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: There were policies and procedures for risk management, both corporate and clinical. The organisational chart for risk management showed three governance committees with responsibility for specific areas - namely clinical committee; business risk management and facilities committee; and risk and safety committee. Each committee reported to the senior management team. The clinical risk management policy addressed the procedures for risk assessment and management, the mitigation of risks such as absent without leave, suicide and self-harm, assault, accidental injury to self or others. There were defined procedures for the identification of risks throughout the approved centre and for the recording, investigation and learning from incidents. There was an integrated risk register for the approved centre. There was an emergency plan in place. The policies and procedures included the protection of vulnerable adults and children. Specific staff were assigned responsibility for child protection.

Training: Staff were aware of the policies and procedures for risk management. Staff were trained in risk assessment and in the recording, reporting and investigation of incidents. Staff were trained in the protection of vulnerable adults from abuse and in child protection.

Monitoring of Compliance: Individual risk assessment and management was monitored by the MDT. Incidents were recorded and audited and this enabled the approved centre to identify its top seven clinical risks. The senior management team reviewed the risk register twice a year.

Evidence of Implementation: The risk register had been reviewed in May 2015. The minutes of the governance committees and the incident report forms were inspected and showed that risks and incidents were managed in a proactive and prompt manner. Each resident was risk-assessed at the time of admission and risk management was integral to the ICP

process. The MDT reviewed risk assessment as clinically indicated and particularly at transitional stages of care such as leave and discharge. A ligature anchor point audit had been completed. SEH provided a six-monthly summary report on incidents and sent death notifications 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 | |

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 approved centre provided insurance certificates for inspection. SEH was indemnified in respect of property and buildings, personal injuries, employer liability and clinical indemnity.

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 prominently displayed in the entrance hallway.

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

SEH admitted voluntary residents only and therefore 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 |

4.2 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

Seclusion was not used in the approved centre and 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

Mechanical restraint was not used in the approved centre and 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 |

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

The approved centre did not admit detained patients and Part 4 of the Mental Health Act 2001 Consent to Treatment 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 |

6.0 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: SEH admitted voluntary residents only and physical restraint was not used. There was, however, a SPUH service-wide policy on the use of physical restraint which applied in the event of physical restraint being required. The policy met the requirements of this code of practice.

Training: Staff were aware of the policy and procedures and training was up to date in crisis prevention intervention and the management of potential and actual aggression.

Monitoring of Compliance: Physical restraint had not been used in the approved centre.

Evidence of Implementation: Physical restraint had not been used in the approved centre in the period since the previous inspection.

Evaluation of this code of practice was based on the governance and training provision for physical restraint within the 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 | |

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

The approved centre did not admit children and this code of practice 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: There was a policy and procedures about incident reporting and the notification of deaths to the MHC and these met the standard of this code of practice. Staff roles and responsibilities were set out with an identified clinical risk manager.

Training: Staff were aware of the policies and procedures operating in relation to this code of practice. The induction programme included risk assessment and incident reporting.

Monitoring of Compliance: There was evidence of ongoing monitoring and audits in relation to incidents and serious untoward events and deaths. The clinical governance committee and the senior management team reviewed the incident report summaries.

Evidence of Implementation: The deaths of two residents had occurred in 2015 to the date of inspection. Both of these deaths had been notified to the MHC within the specified timeframe. The approved centre had provided six-monthly incident summary reports to the MHC. SEH was compliant with regulation 32 Risk Management Procedures.

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

The approved centre did not admit residents with an intellectual disability and a mental illness, therefore, this code of practice 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 |

6.5 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

Processes: There was a policy and procedures on the use of ECT treatment. ECT was not administered in SEH. Residents were transferred as day patients to SPUH for this treatment and accompanied by a nurse. There was a consultant psychiatrist with responsibility for ECT and designated ECT nurses in SPUH. The approved centre used pro forma ECT assessment and record documents. There was a defined process for educating and informing residents and their families about ECT and for written informed consent to the administration of ECT and to anaesthesia.

Training: Staff were aware of the policy and procedures operating for ECT. Staff were trained to ECT Accreditation Standards (ECTAS) which aimed to assure and improve the quality of the administration of ECT.

Monitoring of Compliance: There were regular ECT audits and an annual audit which informed improvements to the process. The ECT department was ECT Accreditation Service (ECTAS) approved and was rated by them as excellent.

Evidence of Implementation: ECT was administered in SPUH and any resident receiving ECT was transported there as a day patient and accompanied throughout by a nurse. The ECT treatment facility was not inspected as it was located in SPUH. One resident was in receipt of ECT treatment. The responsible consultant psychiatrist had prescribed ECT and documented pre- and post-treatment assessment. The resident's written informed consent to treatment was recorded. Assessment included capacity and cognitive functioning. There was a detailed information booklet about ECT. The anaesthetist had assessed the resident before administering ECT and the resident had provided written consent to the anaesthetic. The records for the administration of ECT and aftercare were well recorded and met the standard of this code of practice.

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 were policies and procedures for admission, transfer and discharge. The policies met the specified standards of this code of practice. A pro forma document was used to record admission, transfer and discharge. The policies clearly outlined staff roles and responsibilities and the timelines for assessments and reporting.

Training: Staff were aware of the relevant policies and procedures. The induction programme informed staff about the policies and procedures and line managers were responsible for signing off to indicate staff were trained specific to their role.

Monitoring of Compliance: Admissions, transfers and discharges were monitored and audited on a daily and monthly basis respectively. A resident satisfaction survey informed quality improvement measures. The clinical governance committee and the senior management committee monitored and reviewed practice and standards. There was a clinical forum to review admissions and protracted discharges.

Evidence of Implementation: The admission records of eight residents were inspected. All admissions were planned and the decision to admit was taken by the consultant psychiatrist. The admission assessment was well recorded and met the standard specified in this code of practice. Nursing staff completed an admission checklist which included a property checklist and the provision of information to the resident. A risk assessment and ICP were completed for each resident. Each resident had been assigned a key worker. The clinical files showed communication with family and carers where a resident consented. The admission assessment took account of the physical and psychosocial functioning of the resident and their life context, including living circumstances, relationships, occupational history and relationships and supports.

No resident had been transferred to another hospital or approved centre.

The clinical files of two residents recently discharged were inspected. Discharge planning was evident from the outset of the ICP process. The discharge ICP took account of the life context of the resident and treatment and the scope of care were targeted at providing optimal support on discharge. Residents were fully informed and involved in their discharge plan and aftercare was agreed and scheduled before the resident left the approved centre. The two clinical files contained a medical discharge summary and letter to GP, a copy of the medication prescription, a nursing discharge checklist and the details of outpatient and aftercare therapies.

Compliance Rating:

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