

Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)



APPROVED CENTRE NAME:	St John of God Hospital
IDENTIFICATION NUMBER:	AC0046
APPROVED CENTRE TYPE:	Acute Psychiatric Service
REGISTERED PROPRIETOR:	St John of God Hospital Ltd
REGISTERED PROPRIETOR NOMINEE:	Ms Emma Balmaine, Chief Executive
MOST RECENT REGISTRATION DATE:	17 May 2013
NUMBER OF RESIDENTS REGISTERED FOR:	200
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	3, 4 November 2015
PREVIOUS INSPECTION DATE:	26, 27 August 2014
CONDITIONS ATTACHED:	None
LEAD INSPECTOR:	Mr Damien Lanigan
INSPECTION TEAM:	Dr Susan Finnerty MCN 009711 Dr Enda Dooley MCN 004155 Ms Lisa Kiernan Ms Lydia Martin Ms Marianne Griffiths
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 John of God Hospital was located in Stillorgan in Dublin and provided both private and public beds. It was an independent hospital catering for those with mental health difficulties and, as an independent facility, it had a national catchment area. There were eight wards and 183 beds. The hospital provided specialist services in addictions, adolescent disorders, eating disorders, acute adult psychiatry and psychiatry of later life. The wards were a mix of old and new buildings but the condition of the wards was good. It also provided a public in-patient service for the catchment area of the Cluain Mhuire Mental Health Services, in South Dublin. On the day of inspection, there were 183 beds with 161 residents, 12 of whom were detained under the Mental Health Act 2001.

2.2 Governance

There was an organisational chart and clear governance structures and processes in place. Minutes of the Clinical Governance, Quality & Safety Executive Committee meetings were provided to the inspection team and evidenced regular senior management meetings and appropriate governance structures.

2.3 Inspection scope

This was an unannounced annual inspection that was conducted on the:

- 3 November 2015 from 09:00 to 18:00
- 4 November 2015 from 08:30 to 17:00

The regulations, rules and codes of practice were inspected against; the Use of Mechanical Restraint was not applicable to the approved centre at the time of inspection.

2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on the 26, 27 August 2014 identified it was not fully compliant in the following areas. The compliance rating achieved in the 2015 inspection is presented below.

Regulation/Rule/Act/Code	Inspection Findings 2015
Regulation 15: Individual Care Plan	Compliant
Regulation 22: Premises	Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Compliant
Regulation 27: Maintenance of Records	Compliant
Regulation 32: Risk Management Procedure	Compliant
Rules: The Use of Seclusion	Compliant
Code of Practice: Admission of Children	Compliant
Code of Practice: Notification of Deaths and Incidents	Compliant

Code of Practice: Admission, Transfer and Discharge	Compliant
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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

Regulation/Rule/Act/Code	Risk Rating
Regulation 4: Identification of Residents	Moderate
Regulation 29: Operating Policies and Procedures	Low
Code of Practice: The Use of Physical Restraint in Approved Centres	Low

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these are included in the report, in the relevant areas.

2.7 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 6: Food Safety
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 14: Care of the Dying
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programmes
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Regulation 24: Health and Safety
Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 28: Register of Residents
Regulation 30: Mental Health Tribunals
Regulation 32: Risk Management Procedure
Regulation 33: Insurance
Regulation 34: Certificate of Registration
Rules: The Use of Electro-Convulsive Therapy
Rules: The Use of Seclusion
Code of Practice: Notification of Deaths and Incident Reporting
Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities
Code of Practice: The Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

2.8 Areas of good practice identified on this inspection

- There was a clear focus on recovery at the centre of care for residents in the approved centre.
- There was a wide range of therapeutic activities that supported the residents' journeys through their hospital stay.
- Staff engaged with residents in a warm and dignified manner during interactions.
- There was a strong culture of monitoring and auditing of standards across the approved centre.
- There was continual improvement planning and upgrading programmes for the approved centre with the focus on quality improvement at its core.

2.9 Reporting on the National Clinical Guidelines

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

2.10 Resident Interviews

Residents were greeted by inspectors during the course of the inspection and were invited to meet with the inspectors if they wished. The inspection team also visited individual units and talked with residents. The inspection team was interested to hear the views and experiences of residents in the approved centre. Residents shared their experiences of their journey through the care provided and insights and comments into their experiences in the approved centre.

A common theme was that staff addressed each resident by name and were respectful and supportive in their approach. Residents had a good understanding of their individual care plans and expressed satisfaction about their care, the level of information received, activities provided and discharge planning.

Residents commented about the quality and choice of meals provided. Concern was expressed by one resident about the lack of privacy where residents were sharing double rooms in the approved centre. Concern was also expressed about communication difficulties experienced with the admitting doctor during the admission process.

Overall, residents expressed satisfaction with the service and care that they had received in the approved centre.

2.11 Feedback Meeting

A feedback meeting was held on 4 November 2015. It was attended by:

- The Registered Proprietor nominee
- The Clinical Director
- The Director of Nursing
- The Occupational Therapy Manager
- The Principal Psychologist
- The Principal Social Worker

- The Head of Operations and Quality
- The Human Resources Officer
- The Head of Pharmacy
- The Deputy Director of Nursing
- The Clinical Nurse Manager (CNM 2) from Ginesa unit

The inspection finished on day two with a feedback meeting between the inspection team and the senior management team at the approved centre. This meeting served to facilitate the provision of feedback regarding the findings of the inspection together with an opportunity for representatives of the service to clarify any issues arising from the inspection.

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 process for the identification of residents. The process outlined the use of photographs and wristbands. There was no defined process for identification in the event of two residents with the same name on clinical documentation.

Training: Staff were aware of the processes in relation to identification of residents.

Monitoring of Compliance: The approved centre conducted an audit of compliance with their policy. The audit was limited to whether or not a photograph was attached to the clinical records.

Evidence of Implementation: Clinical files of residents were examined. In the case of the electronic patient records and the paper-based clinical files and medication administration records (MARs) maintained at unit level, there was evidence of multiple unique identifiers in use. These included patient name, photograph, date of birth and medical record number. There were single sheet clinical records in use in the units. These included vital signs recording sheets, weight charts, fluid balance charts, absence without leave forms, special observation forms and patient property receipts. In all documents examined, it was evident that only one identifier was in use with the exception of the vital signs recording sheet which contained a resident's addressograph in all cases.

Staff articulated on interview a process whereby similar named residents could be identified on MARs; however, no process existed for identification of similar named patients on any other part of the residents' records.

The approved centre was non-compliant with the regulation as it did not make arrangements to ensure that each resident was readily identifiable by staff when receiving healthcare or other services.

Compliance Rating:

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

Risk Rating:

Low	Moderate	High	Critical	Not - Applicable
	x			

3. Regulation 4: Identification of Residents

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	15 th December 2015			
CAPAs	Specific	Measureable	Achievable & Realistic	Time-bound
<i>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</i>	<i>Define the area of non-compliance addressed by this CAPA</i>	<i>State method of evaluation and monitoring of outcome</i>	<i>State feasibility of action</i>	<i>State time-frame for completion of action</i>
1.Single sheet clinical records amended to include more than one resident identifier. Action is corrective and preventative. Post-Holder(s):Lesley Vard, Director of Nursing	Ensures each resident can be readily identified by staff using more than one unique identifier.	Check that all Suites are using the revised forms from 24.12.2015 and include as part of the audit for compliance with regulation 4 in the annual audit schedule	Feasible	24.12.2015 Audit in 2016 as per annual audit schedule which will be agreed at February 2016 Clinical Governance Quality & Safety Executive Committee

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 processes in place with regard to food and nutrition in the approved centre that addressed the provision of water and food to residents.

Training: Staff were aware of and understood the processes with regard to food and nutrition.

Monitoring of Compliance: There was a residents' feedback and rating form that provided an opportunity for the catering team to assess residents' comments on food quality and satisfaction. No monitoring of the processes regarding food and nutrition was carried out in the approved centre.

Evidence of Implementation: Residents' intake of food was monitored and weights were recorded. Where special diets were indicated, multi-disciplinary input was documented. Menus were operated on a seven-week cycle with elements of choice evident. Special diets were supplied where indicated by clinical need or religious or cultural requirements. There was access to a safe supply of fresh drinking water throughout 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		

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: There was a policy in place on this regulation. This addressed the provision of standards and facilities for the refrigeration, storage, preparation, cooking and serving of food and disposal of food and related refuse.

Training: Catering staff had received Hazard Analysis and Critical Control Points (HCCAP) training.

Monitoring of Compliance: Food temperatures were monitored and a log of the temperatures was maintained. Fridge temperatures were taken on daily basis and a log of these was also kept.

Evidence of Implementation: All food for the approved centre was prepared in the main kitchens on campus and transported to the units in hot trolleys. Catering staff were observed to perform good hand hygiene and there were separate hand hygiene sinks. Personal protective equipment was observed to be worn by staff as appropriate. The kitchen area was observed to be clean and there was a regular cleaning schedule to maintain food safety. There were appropriate facilities available to allow for receiving, preparation and storage of food. Waste was appropriately disposed of. There was an Environmental Health Officer report for the approved centre. The ward dining areas were observed to have crockery and cutlery appropriate to the residents' needs. There was a logbook in each dining area to capture resident and staff feedback on the dining experiences.

Compliance Rating:

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

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There was a process for the management of residents' clothing. There was a process in place to provide a resident with additional clothes, if necessary.

Training: Induction programme for staff covered residents' clothing. Staff were aware of the process.

Monitoring of Compliance: There was no monitoring of the processes with regard to clothing.

Evidence of Implementation: All residents were up and dressed in day clothing. Residents had their own allocated lockable wardrobe. The residents had their own clothing that ensured their dignity and integrity. Residents were supported by staff to maintain their own clothing. There were laundry facilities on site. Access to an emergency supply of clothing was available.

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: There was a policy and process in relation to residents' personal property and possessions that addressed recording resident property, keeping records separately from the care plan and residents' access to their property.

Training: Training on induction addressed residents' property and staff were aware of the processes involved.

Monitoring of Compliance: Auditing of compliance with the approved centre's policy was evident.

Evidence of Implementation: All property was recorded on admission in a property checklist. A copy of the property list was placed in clinical files, separate to the residents' individual care plans. Where valuable items or cash were brought into the approved centre, there were facilities for safe-keeping. Residents were permitted to keep their property with them and residents' wardrobes were lockable.

Compliance Rating:

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

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a policy and process in relation to the provision of recreational activities for residents at the approved centre.

Training: Relevant staff were trained in the provision of recreational activities.

Monitoring of Compliance: There was documented evidence of auditing attendance at occupational therapy sessions and resident feedback surveys were undertaken.

Evidence of Implementation: There was information available to residents on all wards outlining recreational activities programmes. Risk assessments of residents were carried out and were part of the individual care plans (ICPs). There was sufficient resourcing of recreation with a range of activities available within the approved centre. These included yoga, gymnasium, pet-assisted therapy, creative writing, cookery and singing. There was good access to safe outdoor and indoor spaces for the facilitation of activities. There were scheduled timings for individual units to access internal leisure spaces. It was apparent that there was meaningful attention placed upon recreation and activities for the residents.

Compliance Rating:

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

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: There were defined processes and a policy in place to facilitate residents' religious practices.

Training: Staff were aware of the processes and of the policy.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: There was a church in the approved centre which residents could access if they so wished. Access to ministers of various faiths could be facilitated as necessary. Care provided to the residents was cognisant and respectful of religious beliefs. Recording of religious status obtained on admission guided staff in addressing residents' religious needs.

Compliance Rating:

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

3.11 Regulation 11: Visits

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy in place on this regulation. There were processes for children visiting and for visiting times to be flexible to meet the needs of the residents.

Training: Staff were aware of the policy and the processes for its implementation.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: Visitors were welcome to visit in the residents' bedrooms and in the common areas on the wards or in the coffee shop of the approved centre. Visiting times were displayed using clear signage at various points around the approved centre and in the Information Booklet given to all residents on admission. Visiting times were reasonable and flexible. Staff were cognisant of each resident's unique requirements with regard to visiting and facilitated resident requests as far as was practicable. There was a dedicated visiting room for families with children provided.

Compliance Rating:

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

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: There was a policy in place on communication that covered both incoming and outgoing communication.

Training: Staff interviewed indicated awareness of the policy and the processes for its implementation.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: Residents had access to various forms of communication such as mail and internet access. Residents could retain their own mobile phone except where risk assessment determined that this would be detrimental to the residents' health and safety. Resident ICPs showed assessment of communication needs. Public phones were available on all wards.

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 defined process and policy on searches. The policy specified the procedures for searching with and without consent. The policy also described the process for carrying out a search and identified that residents be informed of the process prior to a search being carried out.

Training: Training on searches was conducted at induction. Staff were aware of the policy and the processes involved in searching in accordance with the approved centre's policy.

Monitoring of Compliance: There was no evidence of monitoring of the search processes.

Evidence of Implementation: Staff reported that searches were performed at the approved centre. Staff conducted risk assessments of residents on admission that informed searching of residents' belongings. Residents were informed of the reasoning and consent was sought. Two nurses conducted the search and were cognisant of gender. Searches were documented on a search form. Privacy and dignity were maintained during searches.

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 were policies in place on the care of the dying which identified the necessity to address the physical, emotional and spiritual needs of residents who were dying. It also addressed the religious needs of the resident; that dignity and propriety were maintained; and that families and carers were to be supported.

Training: Staff were aware of the policy and the processes involved in the care of a dying resident.

Monitoring of Compliance: The approved centre maintained records of deaths as part of their incident reporting. They also sent notifications of deaths to the Mental Health Commission (MHC).

Evidence of Implementation: There had been two resident deaths since the last inspection. The MHC was notified within the required timeframe. Residents who were at end of life stage were accommodated in single rooms which provided privacy. There was good collaboration with the local palliative care team who provided advice and expertise at end of life stages. The clinical files recorded Do Not Attempt Resuscitation (DNAR) orders, where applicable.

Compliance Rating:

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

3.15 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 were two policies in place pertaining to this regulation - care planning and keyworker policies.

Training: Training on the provision of individual care plans (ICPs) was covered in the induction programme. Staff demonstrated awareness of these policies and processes.

Monitoring of Compliance: Weekly auditing of the multi-disciplinary team (MDT) care planning was evident. There was also an audit conducted in April of 2015 that addressed individual care planning.

Evidence of Implementation: All resident clinical files that were inspected contained an ICP and this was recorded in a composite document. Residents were assessed on admission. There was MDT involvement in the ICP process and assessments were reviewed at MDT meetings weekly. There was evidence of resident involvement in this process. ICPs had needs, goals, interventions and resources documented and were individually tailored to the residents' needs. Each resident had a keyworker assigned to them who had responsibility for coordinating care from admission through to discharge. ICPs included up-to-date risk assessments that informed care. ICPs for residents who were children had included educational requirements.

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 and a defined process to ensure residents had access to a range of therapeutic services and programmes.

Training: All staff providing therapeutic services and programmes were trained mental health professionals with experience of provision of therapeutic programmes.

Monitoring of Compliance: There was evidence of ongoing auditing of therapeutic services and programmes with analysis used to inform continual improvements in service. Resident feedback was achieved using surveys.

Evidence of Implementation: There was a range of therapeutic services and programmes provided at the approved centre. Information was provided to residents on the range of activities available. Therapeutic services and programmes that were provided were appropriate to residents' needs and aimed at restoring optimum levels of functioning and residents' ICPs reflected this. The types of therapeutic services available in the approved centre included dietetics, occupational therapy, social work, clinical psychology, Mental Health Promotion, Later Life programme, Wellness Recovery Action Planning and Pastoral Care programmes.

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

Processes: There was a policy in place on children's education. There was a process for assessment of a child's education needs.

Training: Staff had received appropriate training in child protection from Tusla Child and Family Agency. However, this was not up to date for all staff. Teaching staff were appropriately trained.

Monitoring of Compliance: Feedback was received weekly from residents on the education received. There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: There was one teacher and two teaching assistants at the approved centre. There was formal assessment of the educational needs from admission. Individual educational plans (IEPs) were developed for all residents as part of individual care plans (ICPs). Teaching staff liaised with residents' individual schools. Education timetable was given to all residents. Teaching staff had input into the residents' ICPs. Classroom facilities were observed to be sufficient for the provision of education to residents.

Compliance Rating:

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

3.18 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 in place on the transfer of residents that addressed the procedure for transfers to other centres. This included the information to be conveyed and retained relating to the transfer.

Training: Staff were aware of the policy and the processes involved in the transfer of residents and their roles within that process.

Monitoring of Compliance: There was no evidence of monitoring of adherence to the policy.

Evidence of Implementation: The clinical files from one resident and one patient who had been transferred were examined. Pre-transfer assessments and risk assessments were undertaken. Decisions to transfer were documented. The resident consented to the transfer. In the case of the patient, the relevant statutory transfer forms were completed.

There was MDT involvement in the decision-making processes and coordination by the keyworker was evident. Communication with the receiving centre was established and handover of care was facilitated. All relevant clinical records were transferred.

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: There was a policy on the management of medical emergencies and processes evident for the management of general physical health needs of the residents in place.

Training: The medical and nursing staff all had training in general health management and demonstrated awareness of the policy on medical emergencies. An ongoing training programme was in place and training logs were maintained. Basic life support (BLS) and medical emergency training was evident.

Monitoring of Compliance: Auditing was evident on the maintenance of emergency equipment.

Evidence of Implementation: Medical and nursing staff provided ongoing management of residents' general healthcare needs and access to outside healthcare, where appropriate, was observed in clinical files. The ICPs of the residents identified general health needs and residents that were there over six months had physical reviews completed. Staff were aware of how to access national screening programmes, as required for residents. Assessments were conducted in private spaces that ensured privacy and dignity for the residents.

Compliance Rating:

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

3.20 Regulation 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

Inspection Findings

Processes: There was a policy in place on the provision of information to residents. This did not cover interpretive services, staff training or monitoring. There was also a policy on advocacy services.

Training: Staff were aware of the process involved in the provision of information to residents. Information-giving was part of induction training.

Monitoring of Compliance: There was evidence of auditing of provision of information to residents in relation to medication information.

Evidence of Implementation: An information booklet was accessible by all residents in the approved centre which outlined an introduction to care planning, housekeeping, hospital facilities, visiting times, advocacy, complaints and MDT information. Information was evidence-based and readily available in the approved centre. Communication needs were assessed by nursing staff as part of the admission process. Residents had access to interpretation and translation services if required. There was evidence of written, verbal and visual information being disseminated throughout the approved centre. There were meetings every three months between advocacy services and management in the approved centre. A project was in progress to address provision of information to residents called *Mental Health First Aid*. An information centre was under development with input from the consumer council. Individual assessment of residents' communication needs was evident in the care planning process with MDT assessment continuing throughout the residents' admission. These assessments aided how information was provided to residents. Information was provided on diagnosis, medication and MDT care plans to the residents. This information was given verbally by the MDT and in written format as information leaflets.

Compliance Rating:

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

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There was a policy in place on this regulation. It addressed roles and responsibilities with regard to privacy and dignity for the residents.

Training: Training on induction covered the privacy and dignity of the residents.

Monitoring of Compliance: There was no evidence of monitoring of the process.

Evidence of Implementation: Staff described how they respected privacy and dignity during care and treatment of residents. Residents were observed to be treated by staff in a manner that protected their privacy and dignity. Staff acted in a kind and patient manner that was respectful of residents. Residents were called by their preferred name. Space for residents to have time alone could be facilitated on all wards in the approved centre. Private visiting could be facilitated in residents' own bedrooms. Staff were observed to knock before entering residents' rooms.

Consultations and examinations were facilitated in private areas.

Bedrooms in the approved centre were single or double occupancy rooms. In double rooms, curtains were evident around each bed. In single rooms, observation panels could be occluded. Bathrooms had individual locks that could be overridden if necessary. Bedrooms and outdoor spaces were not overlooked. Residents were observed to be dressed in their own individual clothing which supported the residents' dignity.

Closed Circuit Television (CCTV) monitors were not visible to other residents or visitors. Residents had access to their own mobile phones. Public phones were available and located in quiet areas of the units. Resident records were maintained in locked offices and on computer. Resident interviews indicated that privacy was respected.

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 was a process in place for the maintenance of the premises and a process for the continuing development of the premises. There was a process for maintaining a cleaning schedule and infection control was managed by a designated infection control nurse. Utilities were managed by the maintenance staff in the approved centre.

Training: Staff employed in the facilities department at the approved centre were appropriately qualified. The induction programme included a presentation on the premises.

Monitoring of Compliance: Monitoring and auditing of adherence to schedule of upgrading works to address ligature points were evident by the clinical governance, quality and safety executive committee (CGQSE).

Evidence of Implementation: The premises was clean and maintained in a good structural and decorative state. It was brightly lit and adequately heated and ventilated.

Routine maintenance issues were reported and there was evidence of ongoing upgrade and general maintenance of the approved centre in operation during the inspection. There was evidence that upgrading of facilities was planned and implemented with regard for residents' needs.

The premises was comfortably furnished and residents' comments reflected this. The premises was wheelchair-accessible with lifts to access all areas of resident care.

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 was a policy in place on medication management that addressed the ordering, prescribing, storing and administration of medicines.

Training: Training on this regulation was part of overall professional training. Staff were aware of the processes involved.

Monitoring of Compliance: There was evidence of a number of audits relating to aspects of the medication processes. Examples included good prescribing practice, provision of medication information to residents, medication reconciliation and assessment of anti-psychotic side effects.

Evidence of Implementation: Medication was managed in accordance with legal requirements. Staff had access to up-to-date information on medication management. Medication error reporting was evident on the online incident reporting system and there was a positive and open culture supporting this.

Each resident had a Medication Administration Record (MAR). Reconciliation of medication on admission with the referring body was evident. Prescriptions were well written and Medical Council Registration Numbers recorded in the signature bank in the MAR. Medications were administered by two registered nursing staff and were checked prior to administration. There was a system by which similar named residents could be identified on the MARs. Medications administered were documented as was refusal or withholding of medication.

The controlled drugs process involved two staff. The controlled drugs stock inspected corresponded with the controlled drugs register.

Medication was stored appropriately in locked trolleys and fridges. The emergency trolley was checked regularly and documentation of these checks was observed.

Compliance Rating:

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

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a policy in place on this regulation. There were site-specific safety statements for the individual units within the approved centre.

Training: Relevant staff had received training appropriate to their area of work. Training logs were inspected and documented training in fire safety, manual handling, BLS, falls risk assessment, infection control and risk management training.

Monitoring of Compliance: There was evidence of monitoring in respect of health and safety. Audits included fire safety, falls and ligature audits.

Evidence of Implementation: The clinical governance, quality and safety executive committee (CGQSE) reviewed health and safety issues. There was an awareness of roles and responsibilities in relation to health and safety procedures as demonstrated when the fire alarm was activated during the inspection (once as part of regular testing and once as a real activation) and staff implemented their roles well.

There was safety signage, safety information leaflets and equipment maintained throughout the approved centre. There was an emergency plan for the approved centre. Incidents were logged electronically.

There was evidence of continuing risk assessment at individual resident level and at organisational level. There was evidence of a structured programme for addressing ligature points within the approved centre.

Safety representatives were elected and facilitated in their roles.

Environmental health officer reports, fire safety report and incident logs were made available on inspection.

Compliance Rating:

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

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

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy in place on the use of Closed Circuit Television (CCTV).

Training: There was no evidence of training on the use of CCTV.

Monitoring of Compliance: There was no evidence of monitoring of the use of CCTV.

Evidence of Implementation: There was clear signage in prominent positions regarding CCTV use. Monitors were maintained where only health professionals could view them. CCTV was pointed out to inspectors upon request.

CCTV was not recordable at the approved centre except at the exits and outside and this was used for security purposes only.

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 was a policy in place on this regulation and this addressed the process of recruitment, selection and vetting of staff.

Training: Staff were trained commensurate with their roles; there was a clear process for access to education for staff and this was facilitated by the approved centre. There was a defined induction process.

Monitoring of Compliance: There was an annual staffing plan for the approved centre based on a staffing needs assessment overseen by the senior management team. Review of the staffing policy was conducted by the human resources management in the Hospitaller Ministries of St John of God.

Evidence of Implementation: An organisational chart was available for the approved centre. Current staffing lists and levels were examined and there was an appropriate number and skills mix of staff relative to the approved centre. There was a manpower planning committee with representation from various disciplines that addressed staffing, based upon service delivery needs.

There was an appropriate person in charge of the approved centre on a daily basis with clear access to the senior management team. Ongoing in-service training and access to further education support was evident. All relevant mental health legislation was available to staff and training on mental health legislation was evident from inspection of training logs. Three human resource files were inspected from varied disciplines and these contained evidence of curriculum vitae, Garda vetting, references, professional qualification and registration where appropriate, identification and contract of employment.

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 was a policy on the management of clinical records and this outlined processes in relation to the creation of, access to, retention of and destruction of records.

Training: All staff were trained in the use of the electronic healthcare record system in operation in the approved centre on induction.

Monitoring of Compliance: Auditing of the resident records was evident on inspection.

Evidence of Implementation: Only authorised staff had access to the records. Staff had an individual login for access to the electronic healthcare records system.

Each resident had an individual record and all information in relation to the resident was maintained in this record. Resident records were maintained securely online and in paper format in locked offices. The records were in good order, had unique identifiers and contained relevant information relating to residents' care. Records were maintained in sequential order.

The Environmental Health Officer's report, the Fire Officer's report and the Health and Safety report were kept in 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	

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

There was an up-to-date register of residents made available to the inspector. It was maintained in electronic format and contained all elements 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 was a process of operating policies and processes review. The policies were approved by the relevant persons. All required policies were reviewed. The policy on physical restraint was out of date.

Training: Management staff were trained in the processes relating to the maintenance and updating of policies.

Monitoring of Compliance: There was no evidence of monitoring of the process. However, there was evidence of policies being updated.

Evidence of Implementation: There was evidence that policies and procedures were developed with input from clinical and managerial staff. Policies incorporated relevant legislation and were appropriately approved. Policies were communicated and available to all staff through the intranet system. The policy layout followed a standardised format.

As the policy for physical restraint was not reviewed annually as required by the Code of Practice on the use of Physical Restraint in Approved Centres, the approved centre was deemed non-compliant with 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			

Risk Rating:

Low	Moderate	High	Critical	Not - Applicable
x				

3.29 Regulation 29: Operating Policies and Procedures

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	15 th December 2015			
CAPAs	Specific	Measureable	Achievable & Realistic	Time-bound
<i>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</i>	<i>Define the area of non-compliance addressed by this CAPA</i>	<i>State method of evaluation and monitoring of outcome</i>	<i>State feasibility of action</i>	<i>State time-frame for completion of action</i>
1. Policy on Physical Restraint has been reviewed and now includes an annual review date. This action is both corrective and preventative. Post-Holder(s): Cathy Shelley, Deputy Director of Nursing	Annual review of policy on Physical restraint	Audit schedule for 2016 will include audit for compliance with Regulation 29	Feasible	Policy has been reviewed and is in date Audit schedule for 2016 will be approved at February 2016 Clinical Governance Quality & Safety Executive Committee meeting

3.30 Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

Processes: There was a policy in place on Mental Health Tribunals that addressed the processes for facilitation of mental health tribunals.

Training: The Mental Health Act administrator and management and clinical staff were trained and were aware of the process involved in facilitating a mental health tribunal.

Monitoring of Compliance: The Mental Health Act administrator maintained a monitoring process to improve the approved centre's support of the mental health tribunal process.

Evidence of Implementation: Information was provided to the patient and opportunity for the patient to seek clarification was facilitated. Staff provided assistance to patients to attend and engage with their tribunals. The approved centre was observed to provide adequate resources to support the tribunal process. There was a dedicated tribunal room.

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 policy in place on this regulation that addressed the roles and responsibilities, complaints process, advocacy, communication and monitoring in relation to complaints.

Training: Staff received training on complaints management on induction.

Monitoring of Compliance: There was no evidence of monitoring of the process. There was a plan to commence auditing of the process on 9 November 2015.

Evidence of Implementation: The complaints procedure was documented in the approved centre's information booklet and signage displaying the complaints procedure was observed to be displayed on the wards.

There were comment cards available in all areas of the approved centre. There was access to an advocacy service.

There was a nominated person responsible for the management of complaints in the approved centre. There was a complaints log and there were timelines outlined for each stage of the process. Complaints were viewed as a learning opportunity by staff at the approved centre and residents were not adversely affected by the process.

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 was policy with regard to risk management. It outlined the roles and responsibilities of staff at the approved centre. The policy contained the processes for assessment of risk in suicide and self-harm, absent without leave, assault and injury to staff and patients and incident reporting. The centre also had individual policies on responding to emergencies and protection of children and vulnerable adults.

Training: Staff received risk management training on induction and on an ongoing basis. Risk management training was provided for on organisational risk, clinical risk and individual risk assessments. Training on the protection of vulnerable children and adults was evident on inspection.

Monitoring of Compliance: Auditing of adherence to the policy was evident and there were audits on fire, falls risk, dangerous goods and services and on the electronic incident recording system. There were defined processes to follow in the identification, assessment, reporting, review and outcomes learning from risks.

Evidence of Implementation: Risk management processes were evident at organisational level and at individual resident level. Incident reporting was maintained electronically on the incident recording system. A risk register was maintained and actions based on risks identified were actively monitored and reviewed by the CGQSE who met monthly. Individual resident clinical files showed that there was involvement of the MDT and the families in the assessment and management of risks.

There was emergency planning that addressed fire, medical emergencies and major emergencies in place.

Deaths were notified to the MHC within the specified timeframe. The approved centre maintained an incident record and a summary of this was forwarded 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 was insured. The certificate of insurance was inspected.

Compliance Rating:

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

3.34 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 approved centre's current Certificate of Registration was displayed in a prominent position in 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	

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

Processes: There was a policy in place on the use of electro-convulsive therapy (ECT).

Training: A designated ECT nurse and a consultant psychiatrist were trained in ECT. All staff were trained in BLS and staff involved in ECT had read and understood the policy on ECT.

Monitoring of Compliance: There were regular ECT audits and an annual audit which informed improvements to the process.

Evidence of Implementation: No involuntary patient had received ECT.

Compliance was assessed against policy, training and monitoring.

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

Processes: A policy on the use of seclusion was in place and reviewed within the last year.

Training: Staff had received training on the use of seclusion including gender and cultural sensitivity and least restrictive practices.

Monitoring of Compliance: Monthly data was collected on seclusion and this was monitored by a management sub-group on Seclusion and Restraint. This group prepared a report on the use of seclusion in the approved centre in March 2015 that was used to inform strategic planning in seclusion reduction.

Evidence of Implementation: The seclusion register for the approved centre was inspected and the clinical files of two patients who were secluded were also inspected. There was evidence that patients had been assessed prior to initiating seclusion. These assessments included risk assessments.

Direct observation of the patients was maintained for the first hour. Nursing reviews took place at two-hourly intervals. Medical reviews took place every four hours.

Alternatives to seclusion were considered. One patient had been secluded for more than eight hours and the extension order was completed.

There was no documented evidence that the patients had been informed of the reasons for seclusion and the actions required to terminate seclusion. The seclusion episode was reviewed by the MDT after the seclusion episode in one of the two files examined. There was no specific seclusion care plan used and no documentation of the seclusions in the patients' ICPs. The seclusion facilities were very clean, with access to toilet and washing facilities. They were heated and ventilated well and furnishings were safe in design and took into account residents' dignity.

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

As mechanical restraint was not used in this approved centre, this rule was not applicable.

Compliance Rating:

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

5.1 Part 4: Consent to Treatment

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

- (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
- (b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

- (a) the patient gives his or her consent in writing to the continued administration of that medicine, or
- (b) where the patient is unable or unwilling to give such consent –
 - i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
 - ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

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

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

Inspection Findings

Processes: There was a policy in place on consent to treatment. This addressed the roles and responsibilities of staff; the process for the assessment of capacity to consent and obtaining consent; and the administration of medication without consent.

Training: Staff were aware of consent requirements and signed that they had read and understood the policy.

Monitoring of Compliance: There was no evidence of monitoring of consent to treatment.

Evidence of Implementation: One patient in the approved centre was there for more than three months. The patients' capacity to consent was assessed and documented. The patient was able to consent to treatment and did consent to receiving specified medication. The patient had signed a written consent to the administration and receipt of that medication. The signed consent form was in the patient's clinical file.

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: There was a policy with regard to physical restraint but this had not been reviewed annually as required by this code of practice. It was dated August 2014 with a review date of August 2017. Processes were evident in the application of physical restraint in the approved centre.

Training: Staff in the centre had received training in the Therapeutic Management of Violence and also Therapeutic Management of Risk. Training logs were inspected. Staff training took place at induction and on an ongoing basis.

Monitoring of Compliance: Monthly data was collected on physical restraint and this was monitored by a management sub-group on Seclusion and Restraint. This group prepared a report on the use of physical restraint in the approved centre in March 2015 that was used to inform strategic planning in restraint reduction. The approved centre policy on restraint was not reviewed annually.

Evidence of Implementation: Staff articulated that physical restraint was used as a last resort after all other de-escalation techniques had been exhausted. Physical restraint was used to maintain the safety of the resident and others and was done in the best interests of the resident. The clinical files of three residents who had been physically restrained were examined. All documentation was completed to an excellent standard. Risk assessment of residents was evident. Information was given to the residents about the reason for the restraint. There was documentation of the restraint episode, evidence of medical review and MDT review with an opportunity for the resident to discuss the restraint episode. Next of kin were informed and, in one case where they were not, there were documented reasons in the resident's clinical file.

As the policy for physical restraint was not reviewed annually as required by the Code of Practice on the use of Physical Restraint in Approved Centres, the approved centre was deemed non-compliant with the 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			

Risk Rating:

Low	Moderate	High	Critical	Not - Applicable
x				

6.1 The Use of Physical Restraint

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	15 th December 2015			
CAPAs	Specific	Measureable	Achievable & Realistic	Time-bound
<i>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</i>	<i>Define the area of non-compliance addressed by this CAPA</i>	<i>State method of evaluation and monitoring of outcome</i>	<i>State feasibility of action</i>	<i>State time-frame for completion of action</i>
1. Policy on Physical Restraint has been reviewed and now includes an annual review date. This action is both corrective and preventative. Post-Holder(s):Cathy Shelley, Deputy Director of Nursing	Annual review of policy on Physical Restraint	Audit schedule for 2016 will include audit for compliance with Regulation 29	Feasible	Policy has been reviewed and is in date Audit schedule for 2016 will be approved at February 2016 Clinical Governance Quality & Safety Executive Committee meeting

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

Processes: There was a policy in place on the code of practice for the admission of children.

Training: Staff received training on the admission of children on induction.

Monitoring of Compliance: A review took place in April 2015 of the adolescent unit by the Quality Network for Inpatient Child and adolescent mental health services (QNIC) accreditation body. This examined the quality of inpatient child and adolescent psychiatric inpatient care through a system of review against the QNIC service standards. This process followed a clinical audit cycle with self-review and peer-review.

Evidence of Implementation: Admission of children to the approved centre was facilitated in the Ginesa unit. All residents in Ginesa were voluntary residents. Admissions were planned, where possible, with a referral process evident. Each resident had an ICP which contained IEPs and ongoing assessment, risk assessment and review by the MDT and the resident and their families. Consent to treatment was sought from parents and guardians and, in the case of 16 to 17 year olds, their views were sought also.

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 in place on notification of deaths and incidents.

Training: Staff were aware of the process for notification of deaths and incident reporting. Training on risk management on induction covered reporting of incidents and deaths.

Monitoring of Compliance: Monthly reports were compiled of incidents and deaths that had occurred in the approved centre by the risk manager.

Evidence of Implementation: Monthly reports by the risk manager were progressed to the CGQSE and management meetings and outcomes presented of the reviews of the incidents. Learning outcomes and opportunities were shared within the approved centre. Deaths were notified to the MHC within the specified timeframe. Incident reports were recorded and available for examination by the inspection team. Summaries of incidents were sent to the MHC every six months.

Compliance Rating:

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

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

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

Inspection Findings

Processes: There was a policy in place giving guidance for persons working in mental health services with people with intellectual disabilities.

Training: There was training evident for staff on the care of residents who had an intellectual disability. Training logs documented this and were inspected.

Monitoring of Compliance: There was no evidence of monitoring as there were no residents with an intellectual disability at the approved centre.

Evidence of Implementation: There was no evidence of implementation as there were no residents with an intellectual disability at the approved centre.

Compliance was assessed against policy 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	

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 in place on the use of electro-convulsive therapy (ECT).

Training: A designated ECT nurse and a consultant psychiatrist were trained in ECT. All staff were trained in BLS and staff involved in ECT had read and understood the policy. Staff were also aware of protocols for the management of hyperthermia, cardiac arrest and anaphylaxis.

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 approved and was rated by them as excellent.

Evidence of Implementation: There was one resident (voluntary) in the approved centre receiving ECT. The resident's clinical file, the Register for ECT and the record of ECT given were inspected.

There was an ECT pack maintained in the resident's clinical file. The ECT treatment was prescribed by the resident's treating consultant. A signed consent form to ECT and anaesthetic was completed by the resident and was placed in the clinical file. The resident was capable of providing consent and this was confirmed by the consultant psychiatrist in the documentation on ECT in the clinical file.

Pre ECT assessments including consent, capacity to consent, anaesthetic risk and mental state were all documented in the clinical file. There was also evidence of pre, during and post ECT assessments of cognitive functioning of the resident.

Information on ECT was provided to the resident. The ECT suite was bright and well maintained. The required tipping trolleys were in use. All drugs required for ECT were stored in a locked press and locked fridge. All required equipment was available and serviced regularly.

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 separate policies on admission, transfer and discharge of residents to and from an approved centre.

Training: Staff were aware of the processes involved and were trained in these processes as part of their professional training.

Monitoring of Compliance: Auditing of the admission and discharge processes was evident. There was no evidence of auditing of transfers of residents.

Evidence of Implementation:

Admission:

Planned and unplanned admissions were structured and had a defined process that was implemented prior to admission and decisions to admit were clearly documented. Assessments were carried out on admission including risk assessments. The families or carers were involved in the admission process. There was evidence of full MDT involvement in the admission and assessment process. Keyworkers were allocated. Clinical files were maintained for all admissions.

Transfers:

Transfer processes were adhered to. Decisions to transfer care of a resident or patient were made by a registered medical practitioner. There was MDT involvement in the decision-making process. Pre transfer assessments, consent (where relevant) and communication of information between the approved centre and the receiving centre were evident. Appropriate transfer of documentation was apparent. Transfers, where possible, took place during the day.

Discharge:

Discharges were a planned process that was documented as part of the ICP. Pre-discharge planning with the resident and the MDT was evident and family involvement in this process was documented. Discharge summaries were prepared and forwarded to the referring body on discharge. Follow-up care was planned, documented and communicated. Records of returns of resident property were maintained. Resident records on discharge were maintained appropriately by 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	