# Mental Health Commission

# Approved Centre Inspection Report

# (Mental Health Act 2001)

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|---|---|
| APPROVED CENTRE NAME: | St Patrick's University Hospital |
| IDENTIFICATION NUMBER: | AC0005 |
| APPROVED CENTRE TYPE: | Acute Adult Psychiatric Service |
| REGISTERED PROPRIETOR: | Mr Paul Gilligan |
| MOST RECENT REGISTRATION DATE: | 01 March 2014 |
| NUMBER OF RESIDENTS REGISTERED FOR: | 238 |
| INSPECTION TYPE: | Unannounced |
| INSPECTION DATE: | 3, 4 December 2015 |
| PREVIOUS INSPECTION DATE: | 9, 10 December 2014 |
| CONDITIONS ATTACHED: | None |
| LEAD INSPECTOR: | Ms Geraldine Corr |
| INSPECTION TEAM: | Dr Enda Dooley MCN 004155<br>Mr Donal O'Gorman<br>Ms Marianne Griffiths |
| THE INSPECTOR OF MENTAL HEALTH SERVICES: | Dr Susan Finnerty MCN 009711 (Acting) |

## Contents

## 1.0 Mental Health Commission Inspection Process

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

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

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

Section 52 of the Mental Health Act (2001), states that when making an inspection under section 51, the Inspector shall:

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

Each approved centre shall be assessed against all regulations, rules, and 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 Patrick's University Hospital was an independent hospital in Dublin on the south west side of the city. The hospital was an acute adult psychiatry service and offered a range of specialist therapeutic services, including for addictions and eating disorders. The hospital was an 18th century listed building that was well serviced by public transport. The premises were well-maintained, clean, bright and wheelchair accessible. There was a pleasant, uplifting and recovery orientated atmosphere within the hospital that was contributed to by the art exhibition, displaying art created by service users, in the main corridor accessing the wards. In addition, there was a dedicated 'Walk in My Shoes' area (Mental Health Awareness Campaign) beside the main entrance. This area displayed shoes decorated by service users and offered information on this initiative.

The hospital comprised eight wards with a total of 238 beds and accepted admissions from all over the country. On the first day of inspection there were 229 residents, of these 11 patients were detained under the Mental Health Act 2001. There were no children being treated in the approved centre.

### 2.2 Governance

There was an organisational chart and clear governance structures were in place. The senior management team met on a monthly basis. The minutes of the clinical council meetings were provided to the inspection team and evidenced robust and appropriate governance structures.

### 2.3 Inspection scope

This unannounced inspection was conducted on:

- 3 December 2015 09:00 – 19:00
- 4 December 2015 08:00 – 17:30

All regulations, rules and codes of practice were inspected against with the exception of the Codes of Practice on Admission of Children and Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities, Regulation 17 Children's Education and the Rules on Seclusion and Mechanical Restraint which were not applicable to this approved centre.

### 2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 9 and 10 December 2014 identified the following area that was not fully compliant:

| Regulation/Rule/Act/Code | Inspection Findings 2015 |
|---|---|
| Regulation 15: Individual Care Plan | Compliant |

## 2.5 Conditions to Registration

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

## 2.6 Non-compliant areas on this inspection

The 2015 inspection showed that St. Patrick's University Hospital was compliant with all applicable regulations, rules and codes of practice.

## 2.7 Areas of compliance rated Excellent on this inspection

| **Regulation/Rule/Act/Code** |
|---|
| Regulation 4: Identification of Residents |
| Regulation 5: Food and Nutrition |
| Regulation 6: Food Safety |
| Regulation 7: Clothing |
| Regulation 8: Residents' Personal Property and Possessions |
| Regulation 9: Recreational Activities |
| Regulation 10: Religion |
| Regulation 11: Visits |
| Regulation 12: Communication |
| Regulation 13: Searches |
| Regulation 14: Care of the Dying |
| Regulation 16: Therapeutic Services and Programmes |
| Regulation 18: Transfer of Residents |
| Regulation 20: Provision of Information |
| Regulation 21: Privacy |
| Regulation 22: Premises |
| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines |
| Regulation 24: Health and Safety |
| Regulation 25: The Use of CCTV |
| Regulation 27: Maintenance of Records |
| Regulation 28: Register of Residents |
| Regulation 29: Operating Policies and Procedures |
| Regulation 30: Mental Health Tribunals |
| Regulation 32: Risk Management Procedures |
| Regulation 33: Insurance |
| Regulation 34: Certificate of Registration |
| Rule: The Use of Electroconvulsive Therapy |
| Code of Practice on the use of Electroconvulsive Therapy for Voluntary Patients |
| Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting |
| Code of Practice on the Use of Physical Restraint in Approved Centres |
| Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre |

## 2.8 Areas of good practice identified on this inspection

- The approved centre had introduced CRAFT (Community Reinforcement Approach and Family Training) during 2015. This programme was a cognitive-behavioural programme designed to empower any family member or concerned significant other living with addiction. CRAFT aimed to teach participants the skills to influence their loved one whether they are in treatment or are treatment resistant. In addition, it aimed to benefit participants by increasing their independence, reducing their own depression, anxiety and anger symptoms even if their loved one does not enter treatment. The first eight-week cycle had been completed by the time of inspection.
- The approved centre had introduced a therapeutic garden in 2015. The garden had four activity areas. The vegetable area produced food to prepare and eat during various cooking groups. The horticulture area had flowers and plants that were used to decorate the hospital. The Chimera area had a gazebo type element to it so residents could sit and enjoy the outdoor area. And the final area was a 'pet area' where residents could bring their own pets in to visit. The aim of the garden was to promote mental, physical and social health and welfare in the residents of the approved centre.
- The approved centre gained ECTAS (Electro Convulsive Therapy Accreditation Service) approval in March 2015.
- The approved centre had introduced a primary health care service into the hospital. A General Practitioner was onsite five half days a week to provide general healthcare services.
- The approved centre had complemented the Information Centre for residents with an online information portal that was available to residents and visitors in the hospital at all times. This ensured that residents and their visitors could have access to information even if the information centre was closed.

## 2.9 Reporting on the National Clinical Guidelines

The approved centre reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. There was a dedicated Infection Control Nurse.

## 2.10 Resident Interviews

The inspection team met with and interviewed 11 residents during the inspection. Overall, the residents were very complimentary of the service they received within the approved centre. They reported that multidisciplinary team involvement and access to therapeutic services was excellent. Residents reported that they found the "Patient Expectations" section of the individual care plan beneficial. However, not all residents had received a copy of their individual care plan. In addition, not all residents were aware of who their keyworker was. A number of residents expressed a desire for nursing staff to approach them on a daily basis for one to one nursing time. All residents reported that the food was excellent and there was adequate choice.

## 2.11 Feedback Meeting

The inspection team met with members of the senior management team at the conclusion of inspection on 4 December 2015. The following individuals were present:

- Registered Proprietor (Chief Executive Officer)
- Clinical Director
- Director of Nursing
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Director of Services
- Director of Human Resources
- Director of Finance
- Director of ICT and Business Development
- Chief Pharmacist
- Mental Health Act Administrator
- Programme Manager for Clinical Governance

The inspection team thanked the staff for their hospitality and cooperation over the course of the inspection. It was noted that staff were very helpful and, where possible, provided all information requested. Each assistant inspector gave an overview of the regulations, rules and codes of practice that they had inspected and took the opportunity to clarify any issues that were outstanding. A number of clarifications were provided and these are incorporated into this report.

## 3.0 Inspection Findings and Required Actions - Regulations

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

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|---|
| **3.1 Regulation 1: Citation** |
| **Not Applicable** |

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| **3.2 Regulation 2: Commencement** |
| **Not Applicable** |

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| **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:* The approved centre had a policy in place in relation to the identification of residents. The policy outlined the required use of a minimum of two resident identifiers, the procedure for same name residents and the procedure for obtaining residents' photographs.

*Training:* Staff were aware of the processes regarding the identification of residents.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the process for identification of residents; in particular the use of photograph identifiers.

*Evidence of Implementation:* A minimum of two identifiers were used for resident identification. Clinical files contained a number of identifiers including photograph, name and address. Where two residents had the same name, a red sticker was placed on the clinical file to indicate that staff should take extra caution.

**Compliance Rating:**

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

### 3.5 Regulation 5: Food and Nutrition

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

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

**Inspection Findings**

*Processes:* The approved centre had policies in place in relation to food and nutrition. The policies outlined the roles and responsibilities of staff, nutritional screening on the ward, and supports for residents with nutritional needs and access to special dietary requirements.

*Training:* Staff were aware of the processes in relation to food and nutrition.

*Monitoring of Compliance:* An independent auditor had completed an audit of the compliance with the processes for food and nutrition.

*Evidence of Implementation:* The approved centre used the St. Andrews Nutrition Screening Instrument (SANSI) for every resident admitted to identify nutritional needs. Nursing staff monitored residents' nutritional intake and, where indicated, weight charts were implemented. There was dietician input into the menus provided and food was nutritional and wholesome. Food was presented in an attractive manner and menus included healthy options. Special dietary requirements (e.g. coeliac, diabetic) were catered for and allergy information was clearly labelled on the menu. Menus were displayed and there was a choice each meal time for residents. Water coolers were available on the wards for residents and hot drinks were facilitated.

**Compliance Rating:**

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

**3.6 Regulation 6: Food Safety**

*(1) The registered proprietor shall ensure:*

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

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

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

*(2) This regulation is without prejudice to:*

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

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

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

**Inspection Findings**

*Processes:* The approved centre had policies in place in relation to food safety. The policies included information on the processes for delivery and storage of food, refrigeration monitoring, food preparation areas, and for cooking food.

*Training:* Catering staff had completed basic food hygiene training that was based on the Hazard Analysis and Critical Control Point (HACCP) training.

*Monitoring of Compliance:* The catering department had undergone a Food Safety Assurance Audit in September 2015. The department was awarded an excellence in food safety. Food temperatures were recorded prior to leaving the main kitchen and on arrival to each ward.

*Evidence of Implementation:* There were hand hygiene facilities available in the kitchen, dining and serving areas. Personal protection equipment was available to staff. A sufficient number of catering staff was employed to ensure that standards relating to food safety could be achieved. There was suitable and sufficient catering equipment, refrigeration facilities, storage and preparation facilities provided to ensure that a high standard of food hygiene was maintained. Catering areas, and associated catering and food safety equipment, were clean. Food was prepared in a manner that reduced the risk of contamination and waste was appropriately disposed of. There was suitable and sufficient crockery and cutlery for residents. The Environmental Health Officer report was available to the inspection team.

**Compliance Rating:**

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

### 3.7 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:* The approved centre had policies in place in relation to resident clothing. The policies outlined the residents' access to clothing, the provision of emergency clothing and the prescription of wearing of night clothes during the day.

*Training:* Staff were aware of the processes in relation to residents' clothing.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for residents' clothing.

*Evidence of Implementation:* Residents were supported to keep their own personal clothes in individual wardrobes by their beds. Residents' clothing was observed to be appropriate and clean. There was an emergency supply of individualised clothing if required. Residents were prescribed night clothing only where there had been a documented risk assessment and the prescription of night clothes was recorded in the residents' individual care plans.

**Compliance Rating:**

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

### 3.8 Regulation 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had policies in place in relation to the residents' personal property and possessions. The policies outlined the processes for managing residents' belongings on admission, access throughout the residents stay and the process for management of residents' belongings on discharge.

*Training:* Staff were aware of the processes in relation to residents' personal property and possessions.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for residents' personal property and possessions.

*Evidence of Implementation:* Residents in seven wards had access to their own personalised safe that they could choose the password for. All residents in Dean Swift ward had a locked drawer but safes were not used in this area due to risk issues. Residents could also have valuables stored in a central safe. Two staff accessed valuables in the central safe and signed for this. A property checklist was completed on admission and was filed in the resident clinical file separate to the individual care plan.

**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:* The approved centre had policies in place in regard to the provision of recreational activities for residents. The policies outlined the scope of recreational activities available to residents and the resource requirements.

*Training:* Staff were aware of the processes in relation to the provision of recreational activities.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for recreational activities; in particular on gym referrals and twilight programme attendance.

*Evidence of Implementation:* There was a wide range of recreational activities available to residents including a library, a computer room, a gym, a therapeutic garden, a music room, arts and crafts, yoga, meditation and games. There was a 'Twilight Programme' in place that provided recreational activities for residents in the evenings and weekends when the main occupational therapy department was closed. There were opportunities for indoor and outdoor exercise and there were communal areas throughout the approved centre for residents. Attendance at recreational activities was recorded.

**Compliance Rating:**

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

### 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:* The approved centre had a policy in place in relation to religion. The policy outlined the process of recording religious and spiritual beliefs and the process for facilitating residents to attend religious services.

*Training:* Staff were aware of the processes in relation to ensuring that residents were facilitated, insofar as was reasonably practicable, in the practice of their religion.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for religion.

*Evidence of Implementation:* Residents had access to multi-faith ministers and were supported to attend local religious services when appropriately risk assessed. There was an oratory available on the hospital campus and residents were free to observe or abstain from religious practice in accordance with their wishes.

**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:* The approved centre had a policy in place in relation to visits. The policy detailed visiting times, procedures for identification of visitors and the facilitation of child visitors.

*Training:* Staff were aware of the processes in relation to visits.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for visits.

*Evidence of Implementation:* Visiting times were prominently displayed in the approved centre. However, there was flexibility with the prescribed times when needed. Visiting times were also available in the residents' information booklet. There was a purpose-built child visiting room that included age appropriate toys and a separate outdoor area. Visitor safety was outlined in the health and safety statement.

**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:* The approved centre had policies in place in relation to communication. These policies outlined the handling of residents' mail and access to communication such as phone, e-mail and internet.

*Training:* Staff were aware of the processes in relation to communication.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for communication.

*Evidence of Implementation:* Individual risk assessments were completed for residents in relation to risks associated with their external communications and these were documented in the clinical file. Staff did not open residents' mail but supervised mail being opened if there was an assessed risk. Residents had access to a phone, e-mail and a fax machine. Residents also had access to internet.

**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:* The approved centre had policies in place in relation to the searching of a resident, his or her belongings and the environment in which he or she was accommodated. The policies outlined the search processes including obtaining consent, searching without consent, and recording of the search and risk assessment of the resident. The policies also addressed the consideration of the residents' dignity and privacy. There was a written policy in relation to the finding of illicit substances.

*Training:* Staff were aware of the policy. Training was provided on induction.

*Monitoring of Compliance:* The approved centre had completed an audit of their compliance with the processes for searches.

*Evidence of Implementation:* The clinical file of one resident who had been subject to a search was examined. A risk assessment was completed in relation to the resident searched and the resident's consent was sought and documented. The resident was informed by relevant staff of the purpose and rationale of the search. A minimum of two staff conducted searches and searches were documented and signed by those carrying them out. The approved centre's search policy was communicated to residents on admission and in the information booklet. If illicit substances were found as the result of a search, two staff would sign for them and send them to the pharmacy department. The Gardaí were notified and they collected the substance from the pharmacy department.

**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:* The approved centre had a policy in place in relation to care of the dying. The policy outlined roles and responsibilities and the identification and implementation of the resident's physical, emotional, social and spiritual needs in relation to end of life care.

*Training:* Staff were aware of the processes in relation to care of the dying. Staff that would provide end of life care were registered nurses and doctors.

*Monitoring of Compliance:* There were no deaths in the approved centre since the last inspection and it was, therefore, not possible for the approved centre to monitor evidence of compliance.

*Evidence of Implementation:* As there were no deaths in the approved centre since the last inspection, the inspection team was unable to assess evidence of implementation.

This regulation was rated on processes and training only.

**Compliance Rating:**

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

### 3.15 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:* The approved centre had a policy in place in relation to individual care planning. The policy outlined roles and responsibilities, admission assessment requirements and the required content of an individual care plan.

*Training:* Staff involved in the individual care planning process were trained healthcare professionals. The approved centre provided additional training on individual care planning for each discipline. Attendance of training was well documented for nursing staff but not for other members of the multi-disciplinary team.

*Monitoring of Compliance:* The approved centre completed audits on compliance with the care planning process and analysed the data. There were no incident reports completed for non-compliance with the processes.

*Evidence of Implementation:* The inspection team reviewed 109 individual care plans in the course of the inspection. All residents had a comprehensive admission assessment completed and all residents had an individual care plan. An initial care plan was developed on admission and a comprehensive care plan was completed at the first multidisciplinary team meeting. The following were evident in the care plans reviewed:

- Needs were included in 100% of care plans (109/109)
- Goals were included in 99% of care plans (108/109)
- Interventions were included in 99% of care plans (108/109)
- Resources were identified in 93% of care plans (102/109). In 21% of care plans (23/109), resources were documented as "MDT" or "team" leading to ambiguous ownership of interventions.

Care plans were reviewed on a weekly basis. This review was completed by the multidisciplinary team and a list of who attended the review was documented. The review process included a section to document new needs or interventions for residents. These new needs were not included in the overall individual care plan. This resulted in not all residents' needs and interventions being documented in one composite care plan. In addition, there was potential for a need or intervention to go without review as every review sheet was not reviewed at each MDT meeting. Where residents received copies of their individual care plan, new needs and interventions noted on the review sheets would not be included.

The approved centre actively sought residents' participation in the care planning process with the use of a "Patient Expectation" sheet on admission and a "Patient Views/Opinions" section on review sheet. The resident was given a copy of the "Patient Expectation" sheet on admission and returned this to nursing staff prior to the first multidisciplinary team

meeting. The “Patient Views/Opinions” section of the care plan review was integrated into the documentation for the review and residents completed this prior to the weekly multidisciplinary review meeting. Residents were not routinely offered a copy of their individual care plan but could request one.

**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:* The approved centre had policies in place in relation to each therapeutic service and programme provided. Roles and responsibilities were outlined and there was a process in place for referring residents to therapeutic services and programmes.

*Training:* Staff providing therapeutic services were registered medical and health care professionals (i.e. nurses, doctors, occupational therapists, psychologists, social workers). In addition, staff were aware of the process for accessing therapeutic services and programmes.

*Monitoring of Compliance:* Each therapeutic service and programme had completed an audit on their compliance with processes.

*Evidence of Implementation:* The approved centre provided an extensive range of therapeutic services and programmes for residents including:

- Psychosis Programme
- Anxiety Disorders Programme
- Addiction Programme
- Bi-Polar Programme
- Evergreen Programme (rehabilitative programme for residents over 65)
- Young Adult Programme
- Eating Disorders Programme
- Depression Programme
- Wellness and Recovery Programme
- Mindfulness Programme
- Links to Well-Being Programme
- Occupational Therapy
- Psychology
- Social Work
- Dietician

Therapeutic services provided were appropriate to residents' needs and well resourced. Each resident's individual need for therapeutic services was assessed at a multidisciplinary team (MDT) meetings and, where necessary, a referral would be made. There were 12 consultant teams providing care to residents within the approved centre. Each team had a full range of MDT members (i.e. doctors, nurses, psychologist, occupational therapists and social workers). Therapeutic services being used by residents were recorded in individual care plans and one to one sessions were recorded in the residents' clinical files. Attendance records were kept at each individual programme and there were dedicated spaces for the provision of therapeutic services.

**Compliance Rating:**

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

### 3.17 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**

There were no children in the approved centre since the last inspection. Therefore, this regulation was not applicable.

**Compliance Rating:**

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

### 3.18 Regulation 18: Transfer of Residents

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to the processes for transfer to and from the approved centre. The policy included information on the criteria for transfer, communication requirements, documentation requirements and the required referral letter. The policy outlined the approved centre's processes for informing and involving the resident's family or representative and the management of the resident's medication and property.

*Training:* Staff were aware of and understood the processes in relation to the transfer of residents. The induction programme for the approved centre included information for staff on the transfer process.

*Monitoring of Compliance:* There was an annual audit on compliance with the transfer processes.

*Evidence of Implementation:* The clinical file of one resident who was transferred to another facility from the approved centre was reviewed. There was evidence that the resident had been assessed prior to transfer and the decision to transfer was justified and documented. The receiving facility met the resident's needs and there was evidence of communication with the receiving facility prior to transfer. The resident and next of kin were informed of the need for transfer and a documented risk assessment was completed prior to transfer. Full and complete documentation including a referral letter, transfer form, a copy of the resident's individual care plan, a copy of medical and nursing notes, copies of recent laboratory results and assessment tools (falls assessment) accompanied the resident on transfer to the receiving facility. The resident's medication and property accompanied them on transfer.

**Compliance Rating:**

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

**3.19 Regulation 19: General Health**

*(1) The registered proprietor shall ensure that:*

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to general health. The policy outlined the requirement for review of physical status at various stages in a resident's treatment, including admission, after a resident is involved in an incident and every six months. The policy clearly outlined roles and responsibilities in relation to general health.

The approved centre had a policy in place in relation to Medical Emergency Response. This policy outlined roles and responsibilities in relation to response to medical emergencies and directed that Basic Life Support (BLS) training must be completed by staff every two years.

*Training:* Relevant staff were trained as part of their professional training in health assessment processes. Twenty-eight per cent of nursing staff did not have up-to-date Basic Life Support Training.

*Monitoring of Compliance:* The approved centre had completed an audit of compliance with general health processes. Analysis of the audit data was completed.

*Evidence of Implementation:* Registered medical practitioners assessed the residents' physical health status on admission. There were appropriate private facilities provided for physical examinations and each resident's privacy and dignity was maintained. Physical health interventions were documented in the residents' individual care plan and the effectiveness of these interventions was reviewed. Records of general health checks were maintained and there were opportunities for residents to engage in healthy choices e.g. healthy diet options, Slí na Slaínte ("Path to Health" – mapped measured routes which use attractive signage at kilometer intervals on established walking routes to help walkers identify the distance they walk) and the gym. Six-monthly physical reviews were completed for the two residents who required them. The approved centre had introduced a primary health care service into the hospital. A general practitioner was onsite five half-days a week to provide general healthcare services. There was access to national screening and residents were provide with information on screening available, where appropriate. There was access to medical emergency equipment and equipment was checked on a daily basis.

**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 process in place for the provision of information to residents. There were defined roles and responsibilities and information was provided to residents on admission by relevant healthcare professionals. Information on the advocacy service was publically displayed and there was a process for providing residents with information on diagnosis and medication.

*Training:* Relevant staff were trained on the processes relating to the provision of information.

*Monitoring of Compliance:* An annual audit on the approved centre's compliance with the processes for provision of information was completed; in particular the distribution of the information booklet on admission.

*Evidence of Implementation:* Residents were provided with a communication booklet on admission. The booklet contained information on housekeeping arrangements; meal-times; the complaints procedure; visiting times; information on individual care planning; information on the multidisciplinary team; details of the advocacy service; and information on resident rights. Residents' communication needs were assessed on admission and any identified needs were incorporated into the resident's individual care plan. There was an information centre in the approved centre that provided access to approved and evidenced-based information on issues pertinent to the residents' needs, including diagnosis and medication. There was also access to an online information portal for residents. Medication information leaflets included information on possible side-effects. There was access to a translation service when required. Health and safety procedures were publically displayed. Residents' personal information was not communicated to third parties without the residents' consent.

**Compliance Rating:**

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

### 3.21 Regulation 21: Privacy

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to maintaining residents' privacy in the approved centre. The policy outlined the approved centre's roles and responsibilities in relation to the maintenance of residents' privacy and methods for identifying and meeting residents' privacy and dignity expectations.

*Training:* Staff were aware of the processes surrounding maintenance of the residents' privacy and dignity.

*Monitoring of Compliance:* There was an audit completed on compliance processes to respect the residents' privacy; in particular on whether residents were wearing day or night clothes.

*Evidence of Implementation:* Each resident had access to space for spending time alone if he or she wished. All residents were seen to be wearing their own individual clothing. Where residents' rooms where shared, there were curtains to protect the residents' individual privacy. Staff were observed to interact with residents in a respectful manner and knocked before entering bedrooms and bathrooms. There were meeting rooms for consultations on wards and physical examinations were carried out in residents' bedrooms. Residents who were not able to attend to their own personal care were assisted by staff in private areas (e.g. bathrooms). Staff discussed confidential information in private areas and private visiting areas were available. All bathrooms, showers and toilets had locks which could be overridden by staff in case of emergency.

**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:* The approved centre had policies in place that set out the processes for the management and upkeep of the premises in the approved centre. Roles and responsibilities were clearly outlined. The policy documents addressed the provision of facilities appropriate to the residents' needs. There was a cleaning schedule and the requirement for continuous assessment was outlined.

*Training:* Staff were aware of the process for dealing with maintenance issues in the approved centre.

*Monitoring of Compliance:* An audit on compliance with the processes for premises had been completed.

*Evidence of Implementation:* The approved centre had been designed and redeveloped specifically for the provision of care and treatment to individuals with mental health difficulties. The approved centre was wheelchair accessible and all wards had access to appropriately sized communal areas. Residents had access to outdoor spaces and there was a programme of maintenance and cleaning. Ligature-free fixtures and fittings were evident throughout the approved centre and the furnishings were suitable. The approved centre was observed to be clean and hygienic. Residents' bedrooms were suitably sized. There was a system in place to notify maintenance of problems or faults and there was back-up power for the approved centre.

The locks on bathroom doors in Temple Ward were faulty and required repair.

**Compliance Rating:**

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had policies in place in relation to the ordering, prescribing, storing and administration of medicines. The policies also contained information on the processes for crushing medication, medication reconciliation, withholding medication, medication refusal, medication errors and self-administration of medicine.

*Training:* Medication was prescribed by registered medical practitioners and only registered nurses administered medication. There was no documented training on the management of medication incidents.

*Monitoring of Compliance:* The approved centre had completed an annual audit on compliance with the processes of medication ordering, prescribing, storing and administration.

*Evidence of Implementation:* On admission, the residents' prescribed and non-prescribed medication was handed over to the admitting nurse and sent to the pharmacy department. Resident's current and past medication were assessed and a Medication Prescription Administration Record (MPAR) was completed by a registered medical practitioner. Fifty-four MPARs were reviewed during the inspection. All MPARs had two identifiers and recorded allergies, medication start dates, frequency, dose and route. Generic medication names and the prescribers' signature and MCRN (Medical Council Registration Number) were present in all MPARs. Five MPARs did not contain medication stop dates. Where appropriate, the need for periodic or routine tests were noted in the MPAR. Resident medication was ordered from an on-site pharmacy department and nursing staff verified the medication as it arrived on the ward.

Medication was administered in accordance with the directions of the prescriber and any advice from the pharmacy department. Expiration dates were checked and two resident identifiers were used prior to the administration of medication. Residents' medication was only withheld following a medical review. Refusal of medication by a resident was documented and reported to the multidisciplinary team. Where appropriate, and following a risk assessment, residents could be permitted to self-administer medication. All medication was prescribed and residents were not permitted to use over-the-counter medication. If a resident required crushed medication, this was prescribed in the MPAR. Controlled drugs were checked by two nurses and details of these were entered into a controlled drug register. Residents' understanding of their medication was actively promoted by staff. Medication information leaflets were available within the approved centre.

Medication was appropriately stored, labelled and packaged. Medication trolleys were locked and secure when not in use and controlled drugs were stored appropriately in a locked press. Fridges were available where a medication required refrigeration. A

temperature log of these fridges was maintained and only medication was stored in these fridges. Each ward conducted a medication inventory every two weeks to check quantity and expiry dates. Medication which was no longer required or past its expiry date was returned to the pharmacy department.

**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:* The approved centre had policies in place in relation to the health and safety of residents, staff and visitors. Roles and responsibilities were clearly allocated and fire safety was clearly addressed. The approved centre had policies governing infection prevention and control and the prevention and management of falls.

*Training:* Fire drills took place twice a year. However, 49% of nursing staff did not have up-to-date fire safety training. Hand hygiene training had been completed by clinical staff and food safety training had been completed by catering staff.

*Monitoring of Compliance:* The approved centre had completed infection control and health and safety audits.

*Evidence of Implementation:* There were publically displayed health and safety signs within the approved centre (e.g. fire notices, hand hygiene, hot water). Fire extinguishers were prominently located throughout the approved centre and there were adequate emergency exits. There was a corporate risk register that recorded health and safety risks. Emergency lighting was provided and an emergency disaster plan was in place. The approved centre had a falls prevention initiative and all residents had a falls risk assessment completed on admission. The approved centre had an infection control nurse and there was sufficient access to hand washing facilities. Staff had access to personal protective equipment as required and healthcare waste was appropriately disposed of. There was a plan in place to manage sharps injuries. The Environmental Health Officer, Fire Officer and Health and Safety Authority reports were made available to the inspection team. The hospital had one vehicle that was included in the insurance schedule and did not require an NCT (National Car Test).

**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:* The approved centre had a policy in place in relation to CCTV. The policy was clear that the purpose of CCTV was not to observe residents.

*Training:* Staff were aware of the processes in relation to the use of CCTV and their role in these processes. Training was not documented.

*Monitoring of Compliance:* The approved centre had completed an audit on compliance with the processes in relation to the use of CCTV; in particular on CCTV servicing. There was no evidence of analysis of the audit data.

*Evidence of Implementation:* CCTV was not used for resident observation. There were clear signs regarding the use of CCTV in public areas and the CCTV did not record images. CCTV was disclosed during the course of inspection to the Mental Health Commission.

**Compliance Rating:**

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

### 3.26 Regulation 26: Staffing

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

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

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had policies in relation to the recruitment, selection and vetting of staff. The policies outlined the need to have an appropriately qualified individual in charge at all times and reflected the necessary legislative and best practice requirements.

*Training:* Relevant staff were trained in the procedures regarding the recruitment, selection and vetting of staff.

*Monitoring of Compliance:* The approved centre had completed an audit on compliance with recruitment processes.

*Evidence of Implementation:* There was an organisational chart available in the approved centre. The approved centre had an appropriate person in charge at all times and staff were allocated to tasks that were reflective of their education and training. There was a planned and actual staff rota showing the staff on duty during the day and night. All staff were recruited and selected in accordance with the approved centre's policy and procedure for recruitment, selection and appointment. All staff were Garda vetted and references were sought. The approved centre had documented evaluations to assess staff performance and competence. Staff were appropriately skilled and qualified and there was orientation and induction for new staff. All staff received job descriptions and terms and conditions of employment. Two staff files were reviewed and they contained CV, terms and conditions of employment, evidence of education and performance evaluations.

There were annual training plans in place and access to further education for staff. However, records for basic life support training, fire and disaster training, manual handling training and crisis prevention intervention training, indicated that not all nursing staff had received these mandatory training sessions as set out in the approved centre's policy.

**Compliance Rating:**

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

### 3.27 Regulation 27: Maintenance of Records

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

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to the creation, access, retention and destruction of records. The policy stated the record retention periods, the process for destruction of records and security measures in place in relation to record storage.

*Training:* Staff were trained on the policies and procedures in relation to maintenance of records during the staff induction process.

*Monitoring of Compliance:* There was an annual audit in place to assess compliance with the processes of maintenance of records.

*Evidence of Implementation:* Residents' records were created, maintained and used in accordance with legislative requirements. Each resident had their own clinical file which was up to date and held securely in a locked nurses' office. Records had multiple resident identifiers and were sequential and well maintained. Records were accessible by authorised staff only and entries made were in black ink and used the 24-hour clock. Continuous assessment and monitoring of residents was identifiable.

**Compliance Rating:**

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

### 3.28 Regulation 28: Register of Residents

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

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

**Inspection Findings**

The approved centre maintained a register of residents. The register contained all the information specified in Schedule 1. Only relevant staff had access to the register that was maintained in electronic format. The register was made available to the inspection team on request and it was updated on a regular basis.

**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:* The approved centre had a policy in place in relation to operating policies and procedures. The roles and responsibilities of staff were clearly defined and the process for developing, authorising, disseminating and reviewing policies was outlined.

*Training:* Relevant staff were aware of the process for updating and reviewing policies and procedures.

*Monitoring of Compliance:* The approved centre had completed an audit for compliance with the processes for operating policies and procedures.

*Evidence of Implementation:* All required policies were in place and reviewed within the required three-year timeframe. The policy on physical restraint was reviewed annually. Input from relevant clinical staff was obtained when policies were being developed and reviewed. Policies were evidence-based and incorporated relevant legislation. New policies or changes to current policies were communicated to staff through the relevant heads of department. Obsolete versions of policies were removed and archived.

**Compliance Rating:**

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

**3.30 Regulation 30: Mental Health Tribunals**

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to Mental Health Tribunals. The policy clearly outlined the responsibilities of staff in relation to the organisation and facilitation of Mental Health Tribunals.

*Training:* Clinical governance staff and the Mental Health Act administrator were familiar with the processes relating to Mental Health Tribunals.

*Monitoring of Compliance:* The approved centre had completed an audit on the compliance with the processes for Mental Health Tribunals. The Mental Health Act administrator informally monitored the processes for Mental Health Tribunals on a continuous basis and made any changes necessary.

*Evidence of Implementation:* Information on Mental Health Tribunals was available and provided to patients in both written and verbal form. Patients were given time to reflect on the information provided and could ask questions regarding the process. The necessary resources and facilities to enable Mental Health Tribunals were provided by the approved centre. Staff were available to attend Mental Health Tribunals with patients.

**Compliance Rating:**

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

### 3.31 Regulation 31: Complaints Procedure

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

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

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

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

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

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to the management of complaints. The policy outlined the process and procedure for the making and handling of complaints within the approved centre. It included information on the timeframes for the complaints process and the recording requirements for formal complaints. There was no reference to records kept for informal complaints.

*Training:* Relevant staff were aware of and familiar with the processes in relation to complaints management. Training was not documented.

*Monitoring of Compliance:* The approved centre had completed an audit of the processes in relation to complaints; in particular on the complaints officer being identified at complaints boxes.

*Evidence of Implementation:* The roles and responsibilities of staff were clear and there was a nominated complaints officer. However, the complaints officer was identified by role and not by name on the displayed procedure. A consistent and standardised approach was implemented in the management of complaints and the process was implemented without fear, favour or prejudice towards either the complainant or the subject of the complaint. Complaints could be made through a variety of methods such as verbal, written or electronic. There was an advocacy service provided in the approved centre and residents could use this service in the making of complaints. The complaints process was well publicised throughout the approved centre and timelines were provided within the resident information booklet. Minor complaints were dealt with locally and complaint logs for formal complaints were maintained by the nominated person. The complainant was informed where timelines were not achieved and of the outcome of the complaint on completion. A

record of the complainant's satisfaction with the outcome was not recorded. Details of complaints, and any resulting actions, were communicated to staff.

**Compliance Rating:**

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

### 3.32 Regulation 32: Risk Management Procedure

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

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

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

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

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

*(i) resident absent without leave,*

*(ii) suicide and self harm,*

*(iii) assault,*

*(iv) accidental injury to residents or staff;*

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

*(e) Arrangements for responding to emergencies;*

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

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

**Inspection Findings**

*Processes:* The approved centre had policies in place on the identification, assessment, reporting and management of risks. There were specific policies in place that outlined the precautions in place to control risks associated with resident's absent without leave, suicide and self-harm, assault and accidental injury to residents or staff.

*Training:* Relevant staff had received training on the identification, assessment and management of risk. Staff were knowledgeable of the process for reporting incidents and associated documentation. In addition, staff were knowledgeable of the clinical risk assessments used.

*Monitoring of Compliance:* There was an audit completed on the compliance with the processes for risk management. The Clinical Governance Committee reviewed all incidents every second week and analysed trends to inform improvements or changes needed.

*Evidence of Implementation:* There was a nominated person with responsibility for risk management in the approved centre and responsibilities were also allocated throughout the approved centre to ensure effective implementation. Formal risk assessment tools were used on admission of a resident and on an ongoing basis. The residents' level of risk was reviewed at every individual care plan review. Residents were risk-assessed in relation to physical restraint and electroconvulsive therapy. Incident report forms were of a standardised template and were easily accessible to staff. There was a corporate risk register and there were robust governance structures in place. Incidents were reported in a timely manner and a weekly incident report was forwarded to each clinical team where residents under their care had been involved in incidents.

**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 in respect to property, employer liability, public liability and clinical indemnity. A certificate confirming this was available to the inspection team.

**Compliance Rating:**

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

### 3.34 Regulation 34: Certificate of Registration

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

**Inspection Findings**

The Certificate of Registration was displayed in the approved centre. It included the name of the approved centre, the registered proprietor and the date of registration.

**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:* The approved centre had a policy in place in relation to the use of Electro-convulsive Therapy. The policy outlined roles and responsibilities, the process involved in the administration of ECT to detained patients under the MHA 2001 and checks to ensure safety in the process.

*Training:* Staff involved in ECT were specifically trained and were familiar with the process. All staff involved in ECT had basic life support training and training was documented.

*Monitoring of Compliance:* The approved centre had completed an audit of the compliance with the processes for the use of ECT. The centre was ECTAS accredited.

*Evidence of Implementation:* The roles and responsibilities in relation to the administration of ECT were defined and understood. ECT was prescribed by the responsible consultant psychiatrist and the patient was provided with adequate information. There was a designated ECT consultant psychiatrist and anaesthetist. There was a designated ECT nurse and a minimum of two nurses (one of whom was the designated ECT nurse) were always present in the ECT suite. The designated nurse checked all necessary equipment and completed documentation prior to administration of ECT treatment. There was a written record of capacity to consent and, where patients were unable to give consent, *Form 16 – Treatment without consent Electroconvulsive Therapy Involuntary Patient (Adult)* was completed. Each patient was assessed prior to each treatment and there was a process for identification of the patient prior to administration of anaesthesia. Treatment was clearly recorded in the patients' clinical file. The patient was required to be fully recovered before leaving the ECT suite. The ECT register was completed appropriately. There was a documented process for dealing with emergencies.

The approved centre had a dedicated ECT suite that had adequate equipment including an emergency trolley, monitoring equipment and a suction machine. A record of the maintenance of the ECT machine was maintained.

**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**

The approved centre did not use seclusion; therefore, this rule was not applicable.

**Compliance Rating:**

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

**4.3 Section 69: The Use of Mechanical Restraint**

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

**Inspection Findings**

Mechanical Restraint was not used in the approved centre. Therefore, this Rule was not applicable.

**Compliance Rating:**

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

**5.1 Part 4: Consent to Treatment**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to consent to treatment. The policy outlined the procedures for obtaining informed consent including the provision of information to the resident and documenting consent. It also clearly outlined the process for continued administration of medicine to a patient for a continuous period in excess of three months (Section 60 of the Mental Health Act). The approved centre also had a 'Volunteered Consent' form.

*Training:* Staff were aware of the processes in relation to consent to treatment and had completed training.

*Monitoring of Compliance:* There were no documented audits of the processes.

*Evidence of Implementation:*
The responsible consultant psychiatrist assessed the patients' capacity to consent and the provision of information was documented. Written consent specified the precise treatment or medication being consented to and the patients' understanding of information provided was documented. There were two patients who were receiving medication for a period in excess of three months and required consent for continued administration of medication. There was a *Form 17-Treatment without Consent Administration of Medicine for More than 3 Months Involuntary Patient (Adult)* completed and filed for both patients.

**Compliance Rating:**

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

## 6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

### 6.1 The Use of Physical Restraint

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to the use of physical restraint. The policy was reviewed on an annual basis and outlined who may initiate and carry out the physical restraint of a resident. The policy also outlined the training for staff and the information to be provided to the resident.

*Training:* Thirty-eight per cent of nursing staff did not have up-to-date Crisis Prevention Intervention Training.

*Monitoring of Compliance:* The approved centre had completed an audit on compliance with the processes relating to the use of physical restraint.

*Evidence of Implementation:* Two clinical files where residents had been physically restrained were reviewed. Physical restraint was only used in exceptional circumstances and in the best interest of the resident. Both restraint episodes were clearly recorded in the residents' clinical files. Residents were risk assessed in relation to physical restraint. Residents underwent a physical examination within three hours of the restraint. Orders for physical restraint were correctly completed and included the designated staff member who led the restraint. One resident's next of kin was documented as being informed and it was documented that the other resident refused to inform their next of kin. There was evidence that both residents had been reviewed by their consultant psychiatrist in a timely manner. Residents were afforded the opportunity to discuss the episode of physical restraint and a copy of the clinical practice form was filed in the residents' clinical files.

**Compliance Rating:**

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

**6.2 Admission of Children**

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

**Inspection Findings**

There were no children admitted to the approved centre since the last inspection. Therefore, this Code of Practice was not applicable.

**Compliance Rating:**

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

**6.3 Notification of Deaths and Incident Reporting**

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

**Inspection Findings**

*Processes:* The approved centre had policies in place in relation to the notification of deaths and provision of six-monthly incident reports to the Mental Health Commission. Roles and responsibilities for these processes were clearly outlined.

*Training:* Relevant staff were aware of the processes in relation to the notification of deaths and incident reporting.

*Monitoring of Compliance:* The approved centre had completed an audit on compliance with the processes for notification of deaths and incidents.

*Evidence of Implementation:* There were no deaths since the last inspection. The Commission had received the six-monthly incident reports as necessary.

**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**

There were no residents in the approved centre with a diagnosis of intellectual disability. Therefore, this Code of Practice was not applicable.

**Compliance Rating:**

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

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

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

**Inspection Findings**

*Processes:* The approved centre had a policy in place in relation to the use of electro-convulsive therapy (ECT). The policy outlined roles and responsibilities, process involved in the administration of ECT and checks to ensure safety in the process.

*Training:* Staff involved in ECT were specifically trained and were familiar with the process. All staff involved in ECT had basic life support training and training was documented.

*Monitoring of Compliance:* The approved centre had completed an audit of the compliance with the processes for the use of ECT.

*Evidence of Implementation:* The roles and responsibilities in relation to the administration of ECT were defined and understood. ECT was prescribed by the responsible consultant psychiatrist and the resident was provided with adequate information. There was a designated ECT consultant psychiatrist and anaesthetist. There was a designated ECT nurse and a minimum of two nurses (one of whom was the designated ECT nurse) were always present in the ECT suite. The designated nurse checked all necessary equipment and completed documentation prior to administration of ECT treatment. Each resident was assessed prior to each treatment and there was a process for identification of the resident prior to administration of anaesthesia. Consent was obtained and recorded. Treatment was clearly recorded in the resident's clinical file. The resident was required to be fully recovered before leaving the ECT suite. The ECT register was completed appropriately. There was a documented process for dealing with emergencies.

The approved centre had a dedicated ECT suite that had adequate equipment including an emergency trolley, monitoring equipment and a suction machine. A record of the maintenance of the ECT machine was maintained.

**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:* The approved centre had policies in place that outlined the processes for admission, transfer and discharge.

The admission policy included information on planned and unplanned referrals, assessment on and post admission, allocation of a multidisciplinary team, resident rights, the use of the individual care plan and inter-agency collaboration.

The transfer policy included information on the criteria for transfer, communication requirements, documentation requirements and the required referral letter. The policy outlined the approved centre's processes for informing and involving the resident's family or representative and the management of the resident's medication and property during transfer.

The discharge policy outlined roles of the multidisciplinary team members, follow-up care, discharge planning, the provision of information to the resident and the role of the resident in the discharge process.

*Training:* Staff were aware of and understood the processes in relation to the admission, transfer and discharge of residents. Staff signed to say they read and understood the policies in relation to admission, transfer and discharge of residents.

*Monitoring of Compliance:* The approved centre had undertaken an audit to monitor compliance with the admission, transfer and discharge processes.

*Evidence of Implementation:*

Admission: The clinical file of one resident who had been admitted to the approved centre was reviewed. The resident's admission was planned and there was a copy of the referral received in the clinical file. The decision to admit was clearly documented. The resident had a comprehensive admission assessment that included current mental state, risk assessment, presenting problems, psychiatric history, family history, medical history, medication on admission, social history and a physical examination. The resident received the approved centre's information booklet on admission and was allocated a keyworker. An individual care plan was developed with evidence of multidisciplinary team involvement. The resident's personal property was checked on admission and a checklist was maintained in the resident's clinical file separate to the resident's individual care plan.

Transfer: The clinical file of one resident who was transferred to another facility from the approved centre was reviewed. There was evidence that the resident had been assessed prior to transfer and the decision to transfer was justified and documented. The receiving facility met the resident's needs and there was evidence of communication with the receiving facility prior to transfer. The resident and next of kin were informed of the need for transfer and a documented risk assessment was completed prior to transfer. Full and complete documentation including a referral letter, transfer form, a copy of the resident's individual care plan, a copy of medical and nursing notes, copies of recent laboratory results and assessment tools (falls assessment) accompanied the resident on transfer to the receiving facility. The resident's medication and property also accompanied the resident on transfer.

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed. The decision to discharge the resident was clearly documented and was planned. The resident and their family were involved in the discharge process. A discharge meeting with the resident, their keyworker and the multidisciplinary team took place. A prescription of current medication and a follow-up appointment were given to the resident on discharge. A comprehensive discharge summary was completed.

**Compliance Rating:**

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