Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	Highfield Hospital
IDENTIFICATION NUMBER	AC0088
APPROVED CENTRE TYPE	Adult Admission Unit and Psychiatry of Later Life
REGISTERED PROPRIETOR	Mr Stephen Eustace
REGISTERED PROPRIETOR NOMINEE	N/A
MOST RECENT REGISTRATION DATE	30 March 2015
NUMBER OF RESIDENTS REGISTERED FOR	110
INSPECTION TYPE	Unannounced
INSPECTION DATE	27, 28, 29, 30 September 2016
PREVIOUS INSPECTION DATE	9, 10, 11 November 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Ms Marianne Griffiths
INSPECTION TEAM	Ms Orla O'Neill Ms Ann Marie Murray Mr Donal O'Gorman
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

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1.0 Mental Health Commission Inspection Process

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

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

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

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

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

Each approved centre shall be assessed against all regulations, rules, codes of practice and Part 4 of the 2001 Act as applicable, 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 risk level of the non-compliance shall be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgement Support Framework. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART).

The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

Highfield Hospital was an independent sector approved centre registered for 110 residents. The recently built (2010) hospital complex was located on the Swords Road, Dublin, amid well-kept parkland. The original hospital had been established in 1825 by Dr John Eustace, and the hospital was now run by fifth and sixth generations of the Eustace family. The premises were modern and spacious. Highfield Hospital approved centre comprised of Hampstead, a 10-bed acute adult psychiatric unit and five psychiatry of old age units - Steele, Tuke, Domville, Pinel and Farnham. There were 102 residents on the days of inspection. Accommodation in the Hampstead Unit was provided as single, en suite rooms.

2.2 Conditions to Registration

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

2.3 Governance

The approved centre provided the inspection team with copies of the minutes of Executive Management meetings. These minutes showed evidence of regular Senior Management meetings with issues like service development, staff training and development being regularly discussed.

2.4 Inspection scope

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

The inspection was undertaken onsite in the approved centre from:

27 September 09:30	to:	27 September at 16:00
28 September 09:00	to:	28 September at 17:00
29 September 09:00	to:	29 September at 18:00
30 September 08:30	to	30 September at 13:30

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on 9, 10, and 11 November 2015 found the approved centre to be compliant in all areas.

2.6 Corrective and Preventative Action plan

All areas were found to be compliant on the last inspection, therefore; there were no corrective or preventative actions to be taken.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 5: Food and Nutrition	Moderate
Regulation 6: Food Safety	Moderate
Regulation 13: Searches	Low
Regulation 15: Individual Care Plans	Moderate
Regulation 19: General Health	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	High
Regulation 26: Staffing	High
Regulation 27: Maintenance of Records	Moderate
Regulation 28: Register of Residents	High
Rules Governing the Use of Mechanical Means of Bodily Restraint	Moderate
Codes of Practice: Use of Physical Restraint	Low
Codes of Practice: Notification of Deaths and Incident Reporting	Low
Codes of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	Low
Codes of Practice on Admission, Transfer, Discharge to and from an Approved Centre	Moderate

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 4: Identification of Residents
Regulation 8: Personal Property and Possessions
Regulation 10: Religion
Regulation 11: Visits
Regulation 18: Transfer
Regulation 24: Health and Safety
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part 4 of the Mental Health Act 2001 was not relevant to this approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 17: Children's Education
Rules Governing the Use of Seclusion
Rules Governing the Use of Electro-Convulsive Therapy
Codes of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients
Codes of Practice: Admission of Children

2.10 Areas of good practice identified on this inspection

- A volunteer programme was in place whereby volunteers worked with the residents in terms of providing 1:1 time, recreational activities and supporting nursing staff.
- The 'Highfield Healthcare Newsletter' had been published as part of an initiative to promote family engagement. This newsletter was attractively presented in an accessible format and included brightly coloured illustrations. The newsletter informed residents and families about new developments and achievements that had recently taken place in the approved centre.
- A 'Patient Experience survey' was rolled out across the approved centre on a monthly basis in order to gather feedback from residents about their admission. A quarterly report on the data gathered from these surveys indicated high levels of resident satisfaction with the care provided, involvement in decision making and the quality of the therapeutic services provided by the approved centre.
- A Green Ribbon Art Therapy exhibition had taken place since the last inspection. This involved the showcasing of resident artwork and photography in the approved centre.
- A new lift had been decorated with the needs of residents with dementia in mind. Other artwork was displayed around the units including the subjects of resident interest.
- A new computerised software system for the documentation of care delivery (EPIC) was in place in Farnham ward.

2.11 Reporting on the National Clinical Guidelines

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

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

There were no residents on leave at the time of inspection.

2.13 Resident Interviews

Two residents were interviewed by the inspectors; one expressed satisfaction with the service provided, that the food was good. One resident was comfortable, happy and stated that the staff were nice. The other resident was less satisfied and stated that the food was not of a good quality but gave no examples or reasons. The team met with two resident family members who expressed high levels of satisfaction with the treatment that was received by the resident. The team also met with a friend of one resident who expressed dissatisfaction with the amount of recreational activities available to Highfield Healthcare residents.

2.14 Resident Profile

The services provided included acute adult mental health care, continuing mental health care/long stay and psychiatry of later life. There were six wards in the approved centre as follows:

1. Hampstead Clinic – 10 beds.
2. Tuke – 20 beds.
3. Steele – 20 beds.
4. Pinel – 20 beds.
5. Domville – 20 beds.
6. Farnham – 20 beds.

Resident Profile:

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	19	72	0	91
	Involuntary Patients	0	1	0	1
	Wards of Court	0	10	0	10
DAY 2	Voluntary Residents	19	72	0	91
	Involuntary Patients	0	1	0	1
	Wards of Court	0	10	0	10
DAY 3	Voluntary Residents	19	72	0	91
	Involuntary Patients	0	1	0	1
	Wards of Court	0	10	0	10

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. It convened on Friday 30 September 2016 and was attended by the Inspection Team and the following representatives from the approved centre:

- Chief Executive Officer
- Clinical Director / Executive Clinical Director
- Director of Nursing
- Clinical Nurse Manager 3 (Mental Health Administrator)
- Clinical Services Manager
- Director of Operations
- Senior Occupational Therapist
- Senior Psychologist
- Quality Risk Manager
- Consultant psychiatrists x2
- Head of Human Resources

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

Inspection Findings

Processes: There was a written policy reviewed February 2016 in relation to the identification of residents. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed to state that they had read and understood the policy and were able to articulate the policy requirements.

Monitoring: An annual audit was undertaken to ensure that there were appropriate resident identifiers in the clinical files. Analysis was performed to identify opportunities to improve the resident identification processes.

Evidence of Implementation: There were a minimum of two resident identifiers detailed in the residents' clinical files. They were person-specific and appropriate to the residents' communication abilities. Photographs were used in wards where residents lacked the capacity to acknowledge their names. Two identifiers were used in cases where residents had similar names.

The approved centre was compliant with Regulation 4: Identification of Residents. As it adhered to all aspects of the *Judgement Support Framework* and it was quality assessed as 'Excellent.'

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: There was a written policy reviewed February 2016 in relation to the provision of appropriate food and nutrition. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a policy log to state that they had read and understood the processes with regard to food and nutrition. Staff were not able to articulate the processes for food and nutrition as set out in the policy and were not aware of the use of the Malnutrition Universal Screening Tool (MUST) tool.

Monitoring: There was a two-week menu plan that delivered a range of wholesome and nutritious foods in line with residents' needs. At the time of inspection, the menu provision was undergoing a systematic review to implement a four-week menu cycle. A review of menu options to identify opportunities to improve the processes was recorded in the audit folder.

Evidence of Implementation: The approved centre's menus were reviewed by a dietician to ensure nutritional adequacy in accordance with the residents' needs.

Residents were provided with a choice of four dinners every day which included hot and cold options. The meals were presented in an attractive manner. Hot and cold drinks were offered regularly to residents. There was a source of fresh drinking water available to residents at all times in easily accessible locations throughout the approved centre.

In two cases nutritional needs were identified by the multi-disciplinary team, but a MUST assessment had not been completed. In one case, where a resident had been identified with nutritional needs, the most recent MUST assessment was completed in 2014.

Weight charts were maintained, where appropriate, and family and/or carers were informed about any special dietary requirements the resident had. In the Pinel unit, intake and output charts were put in place in the event of identified food or nutrition concerns relating to a resident; they were also implemented when a resident was placed on antibiotics.

The approved centre was not compliant with Regulation 5: Food and Nutrition as residents' special dietary requirements were not taken into account as indicated by their individual care plans.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
Low	Moderate	High	Critical	
	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: A written policy reviewed December 2015 was available in relation to food safety. The policy included requirements of the *Judgement Support Framework* with the exception of reference to the controls in place for the disposal of food.

Training and Education: Staff had signed a log to state that they had read and understood the policy and were able to articulate the procedures relating to it. All staff that handled food had up-to-date training in the application of Hazard Analysis and Critical Control Points (HACCP).

Monitoring: An audit folder showed that food safety audits were periodically completed. Audit reviews were undertaken to identify opportunities to improve food safety processes. Food temperatures and refrigerator temperatures on Tuke, Pinel and Hampstead were not logged daily.

Evidence of Implementation: The approved centre provided appropriate hand-washing areas and suitable Personal Protective Equipment (PPE) for catering services. Food was prepared and served with due regard to hygienic practices. The refrigerators in Pinel, Tuke and Hampstead were noted as unclean and the cutlery drawer in the Hampstead unit had brown staining and crumbs in it. There was suitable and sufficient catering equipment and facilities for the refrigeration, storage, preparation, cooking and serving of food. Cutlery and crockery was appropriate to resident needs.

The approved centre was non-compliant with this regulation as a high standard of hygiene was not maintained in relation to the storage of food as required by the Regulation part (1) (c).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There was a written policy reviewed March 2016 in relation to residents' clothing in the approved centre. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a log to state that they had read and understood the policy relating to clothing. Staff on Farnham, Pinel and Hampstead unit were unable to articulate the processes in relation to clothing.

Monitoring: Audits on the process of clothing provision were completed in February 2016 indicating full compliance with the regulation.

Evidence of Implementation: Residents were supported to keep and use their personal clothing. A laundry facility was available to enable residents' washing to be carried out on site. It was observed that all residents were dressed in clean and appropriate day clothes. The emergency supply of clothing in one unit was a random collection of mismatched items that had been donated to the approved centre. However, there was a process in place whereby the occupational therapist had access to funding to purchase spare clothing for a resident if required.

The approved centre was compliant with this regulation. It was quality assessed as satisfactory as the approved centre did not adhere to the Training pillar of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			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: A written policy reviewed December 2015 was available in relation to residents' personal property and possessions. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a policy document to state that they had read and understood the processes and procedures relating to it. Staff were able to articulate the policy.

Monitoring: Personal property logs were maintained and monitored. There was an audit folder with records showing that analysis was completed to identify opportunities to improve the processes for residents' personal property and possessions.

Evidence of Implementation: Personal property and possessions were safeguarded in a property press. Secure facilities were provided on all wards. The property presses on these wards allowed for the safe-keeping of the resident's monies, valuables, personal property and possessions. Property records showed that residents brought personal possessions with him/her to the approved centre, as appropriate, with consideration to the best interests of the resident and their right to dignity, bodily integrity, privacy and autonomy. A signed checklist detailing each resident's personal property and possessions was maintained. The records were kept separate to the residents' Individual Care Plans (ICPs).

Access to, and use of, resident monies was overseen by two members of staff and the resident. Where any money belonging to the resident was handled by staff, a record was maintained. This was counter-signed by the resident.

The approved centre was compliant with Regulation 8. It was quality assessed as 'excellent' as it adhered to all aspects of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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: A written policy reviewed February 2016 was available in relation to the provision of recreational activities. The policy included the requirements of the *Judgement Support Framework* with the exception of the process applied for the development of recreational activity programmes.

Training and Education: Staff had signed a policy document to state that they had read and understood the policy in relation to the provision of recreational activities. Staff were able to articulate the relevant processes and procedures.

Monitoring: The approved centre had conducted an audit and subsequent analysis to identify opportunities to improve the processes for recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the residents in the approved centre. There were timetables and notice boards in each unit displaying planned recreational activities. The recreational activities timetable appropriately reflected the needs of residents for each unit.

The Occupational Therapist (OT) and Recreational Activities Therapist provided one-to-one and group activities on each of the individual units during the week. Nursing staff provided recreational activities over the weekend. Information was provided to residents in an accessible format, appropriate to individual needs. It included the types and frequency of meaningful and purposeful recreational activities available within the approved centre.

The types of recreational activities included reminiscence therapies, hand massage, arts and crafts, relaxation therapies, pet therapy and access to internal gardens and community meetings on the unit. Nursing and activity therapists requested feedback from the residents with regard to recreational activities programmes. Records of participation in recreational activities were maintained and the minutes from community meetings showed that residents were given opportunities to help develop and implement recreational activities.

Individual risk assessments were completed for the residents to ensure that the type of activity was appropriate to their needs. Residents were free to decide if they wanted to participate in any activity provided. The approved centre was designed to include a range of communal recreational areas. There was an enclosed garden available to all residents and their families.

The approved centre was compliant with Regulation 9: Recreational Activities. It was not rated excellent as it was not in full accordance with the Processes pillar of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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: A written policy reviewed December 2015 was available in relation to the approved centre's facilitation of religious practice. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: A signature log was completed to state that staff had read and understood the policy on religion. Staff were able to articulate the processes for facilitating residents in the practice of their religion.

Monitoring: The policy was regularly reviewed to support residents' religious practices. The approved centre carried out an annual audit on religious services for its residents.

Evidence of Implementation: The approved centre had a local chaplain who provided pastoral care to any resident who requested it. The approved centre had a large church on site with additional prayer areas on the Farnham and Tuke units.

Residents were facilitated to go out to religious services where practicable. Residents who wished to attend religious services outside of the approved centre were able to so if accompanied by a family member or next-of-kin following a risk assessment to ensure that it was appropriate.

The chaplain maintained contact with other religious denominations to facilitate multi-faith practice of religious, cultural and spiritual beliefs. Care and services that were provided within the approved centre were respectful of the residents' religious beliefs and values. Each resident was allowed to observe or abstain from religious practice in accordance with his/her wishes. An information book and policy document also detailed the provision for religious observance.

The approved centre was found to be compliant with Regulation 10: Religion and was given a quality assessment of Excellent.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.11 Regulation 11: Visits

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy, dated November 2015, in relation to visits. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: A signature log was completed to show that staff had read and understood the policy on visits. Staff were able to articulate the processes for visits.

Monitoring: The policy on visits was reviewed by the Quality and Risk Management Committee. The approved centre carried out an annual audit to identify opportunities to improve the visiting process.

Evidence of Implementation: Families and visitors were encouraged to visit and were made welcome at the approved centre. Residents were able to receive visitors at the approved centre and, if a risk was identified, a risk assessment was carried out with the resident's involvement. Any visiting restrictions or barrier protection guidelines were clearly communicated to visitors.

The clinical file of one resident was inspected. There was a record of a request to prevent a particular visitor being given access to the resident. The restriction was enforced and the details were recorded in the individual care plan.

Residents received visitors on the unit or privately, in their bedrooms, except where visitors brought children with them. Children under the age of eighteen had to be supervised by an accompanying adult visitor at all times. Those visits were held in the family visiting areas off the unit in the visitor pods. A supply of children's toys was available for child visitors on request.

The approved centre had several visiting areas, called 'pods', on the main corridor where residents could meet visitors in private. The areas were bright and comfortably furnished for two or more people. All visitors signed in and out at the reception area in line with policy and Health and Safety requirements.

The approved centre was compliant with Regulation 11: Visits and was given a quality assessment of 'Excellent' as it was in full accordance with the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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: A written policy reviewed December 2015 was available in relation to resident communication. The policy included requirements of the *Judgement Support Framework* with the exception of the process in place for accessing an interpreter for the residents when required.

Training and Education: A policy document was signed by staff to state that they had read and understood the policy. Staff were able to articulate the policy requirements.

Monitoring: An audit folder held records that showed resident communication needs and restrictions on communication were monitored on an ongoing basis and that analysis was completed to identify opportunities to improve communication processes.

Evidence of Implementation: Risk assessments with regard to incoming and external communications were completed by staff of the approved centre. Residents had access to mail, fax, email, internet (where available), telephone or any device for the purposes of sending or receiving messages or goods. The clinical director, or a senior member of staff designated by the clinical director, only examined incoming and outgoing communication if there was reasonable cause to believe that the communication may result in harm to the resident or to others.

The approved centre was compliant with Regulation 12: Communication. It was not rated excellent as it was not in full accordance with the Processes pillar of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy reviewed November 2015 in relation to resident searches. The policy included the procedures for searching a resident and their belongings, with and without consent, and the process for the finding of illicit substances. The policy included the requirements of the *Judgement Support Framework* with the exception of: the policy did not include the considerations of privacy and gender in relation to searches generally; it only applied to the search of a person.

Training and Education: Staff had signed a record to state that they had read and understood the policy on searches. Staff were not able to articulate the procedures for searching as set out in the policy.

Monitoring: The approved centre did not provide a written record of every search conducted. A member of staff reported that a search had been conducted earlier in the year but there was no record of this search.

Evidence of Implementation: The process in place for searching a resident was not documented in the Tuke unit 'Welcome booklet.' There was no documentary evidence that staff communicated the policy and processes on searches to residents or their families.

The clinical files of two residents who had been searched were examined. In one case, an appropriate risk assessment was carried out prior to the search. Resident consent to the search was recorded on the search form used for the procedure. It was not documented

that the resident was informed of what was happening and why. This search was implemented with due regard to the residents' dignity, privacy and gender. There were two staff in attendance during the search.

In the second case, there was no documentation that the search had taken place at the time reported by staff. Consequently, there was no evidence that resident consent was sought prior to the search, that a minimum of two clinical staff were in attendance and that resident dignity, privacy and gender were respected.

A written record of all environmental searches was kept in the approved centre.

The approved centre was not compliant with Regulation 13: Searches because:

a) The registered proprietor did not ensure that staff and residents were aware of the policy and procedures on searching as required by the (13(5))
b) Not all searches were documented. (13(9))
c) In the case of the documented search, there was no evidence that the resident had been informed of the reasons for the search (13 (8)).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
X			

3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy reviewed March 2016 in relation to the care of the dying in the approved centre. The policy included requirements of the *Judgement Support Framework* apart from the process in place for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere.

Training and Education: Staff had signed a policy document to state that they had read and understood the policy and protocols on care of the dying. Staff were not able to articulate the processes for end of life care as set out in the policy.

Monitoring: The minutes of the meeting of the Multi-Disciplinary Team (MDT) and senior management included a systems analysis in the case of a sudden or unexpected death. End of life care provided to residents was systematically reviewed to ensure that Section 2 of the Regulation was complied with.

Evidence of Implementation: The files of two residents who were cared for at end of life were examined. Both residents had advance directives relating to end of life care, as well as DNAR orders documented in the clinical file. The physical and spiritual needs regarding end of life care was detailed in the ICPs. Psychological, emotional or social needs were not documented in the ICPs or clinical notes.

The privacy and dignity of residents was protected; one resident was nursed in a 4-bed unit at end of life, however this was due to the preferences of the residents' family. The second resident was nursed in a single room. The clinical files contained a record showing that the family of a resident was able to stay overnight at the end of one resident's life. The clinical file also recorded that pain management needs were met.

One resident had passed away suddenly. Funeral arrangements were made in accordance with the faith specified in the resident's ICP and referenced prayers, rituals and religious practices, however this documentation did not clearly define the resident's end of life preferences. All deaths were notified to the Mental Health Commission within 48 hours of the deaths occurring.

The approved centre was compliant with this regulation. It was not quality assessed as 'Excellent' because not all aspects of the *Judgement Support Framework* were met in respect of processes, training and evidence of implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.15 Regulation 15: Individual Care Plan

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

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

Inspection Findings

Processes: There was a written policy reviewed August 2016 in relation to the development, use and review of individual care plans. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a policy log to state that they had read and understood the policy requirements. Staff were able to articulate the policy processes. All MDT members were trained in individual care planning.

Monitoring: An audit of individual care plans had been completed, analysing the content of five ICPs on the Hampstead unit. This analysis was completed to identify opportunities to improve the individual care planning process. A resident experience satisfaction survey was conducted quarterly.

Evidence of Implementation: An initial ICP was developed on admission to address the immediate needs of the resident. A more detailed ICP was developed at an MDT meeting within seven days of admission. The ICPs were saved in the clinical files. None of the ICP documents recorded the staff members involved in the development of the care plan and records did not evidence full MDT collaboration in the development of the ICPs.

A comprehensive assessment of each resident was made on admission and documented in the clinical file. The risk assessment entitled "MDT risk assessment" was completed by nurses only. Evidence-based assessments were used for the resident group profile and recorded in the clinical files. The assessments were appropriate for the resident cohort.

Not all ICPs identified the resources required to provide the care and treatment specified; ICPs recorded a list of interventions and a list of disciplines as responsible for them but did not directly identify who was responsible for them.

Each ICP included an individual risk management plan and a preliminary discharge plan, where deemed appropriate. ICPs were reviewed and updated by the MDT weekly, in an acute setting, and at least every six-months for residents in a continuing care facility. Each resident had access to their ICP and was kept informed of any changes. The resident was offered a copy of their ICP, including reviews.

ICPs in the Hampstead Unit were made on a separate self-adhesive pro-forma template which was pasted into the progress notes section of the clinical file and kept separate from the ICP. Therefore; the ICP was not contained in a composite set of documentation.

ICPs recorded the involvement of a representative, family and next-of-kin and also identified appropriate goals for the resident. The individual care plans also included the care and treatment required to meet those goals including the frequency and responsibilities for implementing them. A keyworker was assigned to each resident to facilitate the implementation and co-ordination of resources for the resident.

The approved centre was non-compliant with Regulation 15: Individual Care Plan because:

(a) The ICPs in the Hampstead Unit were not contained in one composite set of documents.
(b) The ICPs in the residential units did not record MDT input to the development and review of the ICPs.
(c) Not all ICPs contained documented resources.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	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: A written policy reviewed March 2014 was available in relation to the provision of therapeutic services and programmes to residents in the approved centre. The policy included requirements of the *Judgement Support Framework* with the exception of the following:

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

Training and Education: Staff signed a policy document to state that they had read and understood the policy on therapeutic services and programmes. Staff were able to articulate the required processes.

Monitoring: An audit on therapeutic activities was completed. The approved centre had carried out analysis to identify opportunities to improve the processes for therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents. This was documented in their ICPs, time-tabled therapeutic activities and clinical files. Timetables of activities were posted in each unit in the approved centre.

Where a resident required a therapeutic service or programme that was not provided directly by the approved centre, arrangements were made for the service to be provided by an approved, qualified health professional in an appropriate location.

There were adequate resources and facilities to provide therapeutic services and programmes. There was one Occupational Therapist for the approved centre, three Activities Nurses, a 0.8 Whole Time Equivalent (WTE) Social Worker and a 0.5 Clinical Psychologist available for therapeutic interventions. Therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. Therapeutic services available included: reminiscence therapy and

‘physio group fit.’ Participation, engagement and outcomes achieved were recorded in the resident’s individual care plan and clinical files.

The approved centre was found to be compliant with Regulation 16: Therapeutic Services and Programmes. It was not rated excellent as it was not in full accordance with the Processes pillar of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.17 Regulation 17: Children's Education

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

Inspection Findings

Children were not admitted to the approved centre and this Regulation was not applicable.

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: A written policy reviewed May 2016 was available in relation to the transfer of residents. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a policy document to state that they had read and understood the policy on transfers. Staff were able to articulate the processes for transfer of residents as set out in the policy.

Monitoring: There was an audit report which was used as the basis for quality improvement of transfer processes.

Evidence of Implementation: The clinical files showed that an assessment of the resident was completed prior to transfer, including a risk assessment relating to the transfer and the resident's needs. A medical transfer form was completed for each resident transferred and recorded the time and date when he or she was moved from the approved centre to another facility. The information was sent in advance, or accompanied the resident upon transfer, to a named individual.

The documentation regarding the transfer of resident included the letter of referral, with a list of current medications, the resident transfer form and the required medication for the resident during the transfer process. A copy was retained by the approved centre. In the case of emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral as soon as was practicable.

A transfer checklist was completed by the approved centre to ensure comprehensive resident records had been transferred to the receiving facility. All records relevant to the resident transfer process were retained in the resident's clinical file.

The approved centre was compliant with Regulation 18: Transfer of Residents. As it was in full accordance with the *Judgement Support Framework,* it was quality rated as 'Excellent.'

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

Inspection Findings

Processes: There was a written policy reviewed March 2017 regarding the provision of general health services to residents. It stated that each resident's general health needs be assessed regularly as indicated by his or her ICP but not less than every six months and that each resident be given access to appropriate national screening programmes. The approved centre also had a policy for responding to medical emergencies.

The policy included the other requirements of the *Judgement Support Framework* with the exception of the following:

- The protection of resident privacy and dignity during general health assessments.
- The documentation requirements in relation to general health assessments.

Training and Education: Staff had signed a policy log to state they had read and understood the policies on the provision of general health services and for responding to medical emergencies. Staff were able to articulate the appropriate processes.

Monitoring: An audit recorded that national screening programmes were not applicable to the resident cohort. An audit was completed to monitor six-monthly reviews.

Evidence of Implementation: The approved centre had a resuscitation trolley in Hampstead ward. This trolley was checked weekly; however it was not maintained in good order. There was an Automated External Defibrillator (AED) machine available to the approved centre.

Records of medical emergencies that occurred within the approved centre and the care implemented were maintained. Registered Medical Practitioners assessed residents' general health needs at admission and ongoing basis. A General Practitioner (GP) was on site at the approved centre hospital for a minimum of three hours each day, Monday to Friday.

Residents' general health needs were not monitored within the maximum six-month time-frame. In 17 resident records, the general health checks were two weeks overdue at the time of the inspection. Where general health checks were carried out, any subsequent results, including records of any clinical testing, e.g. lab results, were recorded.

A liaison doctor from the Mater hospital had input into Highfield Healthcare on a regular basis and adequate arrangements were in place for resident referrals to other health services as required. There were a number of initiatives to promote a healthier lifestyle,

including programmes to reduce smoking, promote Healthy Eating and promote good back health and posture amongst residents. There was also a programme called Easy Exercises (chair exercises) for older people. As this was an older aged population, general health screening was not applicable to the resident group.

The centre was found to be non-compliant with Regulation 19: General Health due to the fact that in 17 cases the residents' general health assessments were not documented as completed within the previous six months.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.20 Regulation 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

Inspection Findings

Processes: The policies covered the provision of information to residents and included all the requirements of the *Judgement Support Framework* with the exception of the following:

- The process for identifying the residents' preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs, including appropriate translation services.
- Provision of interpreter services available within the approved centre.

Training and Education: Staff had signed a sheet to say that they had read and understood the policy requirements and were able to articulate the procedures relating to them.

Monitoring: An audit log showed that the provision of information to residents was monitored on an ongoing basis. Analysis was completed to identify opportunities to improve the processes.

Evidence of Implementation: A booklet was available on each of the units to provide information. These booklets used complicated language~~:~~ there were no picture aids and the booklet was unsuitable for residents with dementia. Information was given verbally, appropriate to the cognitive ability of the resident. The booklets provided information covering a wide range of house-keeping arrangements including mealtimes and residents' rights. Details of each resident's MDT was provided in booklet form and was displayed on an information board. The process for property management was included in the resident information booklet

Residents were provided with written and verbal information regarding their diagnosis and medication regime in diagnosis-specific information leaflets. The information in the leaflets was evidence-based and referenced the Royal College of Psychiatrists website if further information was required. Residents had access to interpretation and translation services

as required through the Health Service Executive (HSE). No residents at the approved centre required interpreter services at the time of inspection.

Publicly displayed health and safety procedures were in formats that were easily understood and took account of the special communication needs of people using the building.

The approved centre was compliant with Regulation 20: Provision of Information to Residents. It was not rated excellent as it was not in full accordance with the processes pillar of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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: A written policy reviewed March 2016 was available in relation to resident privacy. The Human Resources department had protocols to manage staff found not respecting resident dignity and privacy. The policy included the requirements of the Judgement Support Framework with the exception of:

- The method for identifying a resident's privacy and dignity preferences.
- The layout and furnishing requirements to support resident privacy and dignity.
- The process to be applied where resident privacy and dignity was not respected.

Training and Education: Not all staff had signed to state that they had read and understood the policy requirements. Staff were able to articulate the processes for ensuring resident privacy.

Monitoring: An annual audit was carried out to check standards with regard to privacy requirements. Audit reviews were held to identify areas for improvement in this area.

Evidence of Implementation: Staff wore the required uniforms, used the residents' preferred names and titles appropriately, were respectful and kind in their interactions with the residents and showed empathy with them. Staff demonstrated discretion when discussing a resident's treatment, needs or conditions. Staff knocked on doors before entering any resident's bedroom. All residents during the inspection were observed to be clean and appropriately dressed.

All bathroom showers and toilet doors had working locks (with an override facility). Portable screens were used in the 4-bed room in the Farnham unit; Tuke, Steele and Pinel had single rooms. Domville had one 2-bed room with an appropriate dividing curtain in place to ensure privacy.

The layout of the approved centre and furnishings supported resident privacy and dignity. All resident bedrooms had manual privacy blinds on the doors. These were in working order. The layout of the approved centre's units was appropriately designed to ensure resident privacy and no resident bedrooms were overlooked by public areas. Notice boards did not contain resident names or other identifiable information. Residents had access to a public phone in a private area and were also provided with portable phones on each unit.

The approved centre was compliant with Regulation 21: Privacy. It was not rated excellent as it was not in full accordance with the Processes and Training pillars of the *Judgement Support Framework (JSF).*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was no written policy available in relation to the approved centre's premises.

Training and Education: Staff were able to articulate the protocols for contacting the maintenance and cleaning departments.

Monitoring: There was an audit record regarding hygiene and infection control. Analysis had been completed on a comprehensive audit on premises which identified opportunities for improvement in terms of fixtures and furnishings, resident equipment, dedicated therapy/examination rooms, additional toilet and bathroom facilities, cleaning and hygiene programmes. There had not been a ligature audit since 2015.

Evidence of Implementation: Residents had access to appropriate personal space. Most residents had a single room. The temperature of the bedrooms was comfortable. Rooms were ventilated and both residents and staff could open and close windows in the individual units. The temperature of all units was centrally controlled and staff were able to regulate the heating in the residents' individual bedrooms.

Bedroom windows had safety restrictors in place. Locks were provided on single bedroom doors, where appropriate to residents' well-being, following a suitable risk assessment. Locks were able to be over-ridden by staff. All resident bedrooms were appropriately-sized, comfortable and homely.

There were large communal areas on all the units and smaller quiet areas available to residents and their visitors. There were smoking areas on all units. Residents also had access to external areas except for those residents on the Farnham Unit.

The units had appropriate noise levels/acoustics. The lighting in communal rooms was adaptable and suited the needs of residents and staff. The communal areas were bright and well-lit with large windows positioned to facilitate reading and other activities. A range of assistive devices were used by residents to promote comfort and safety.

There was no dedicated therapy/examination room and residents received treatments and examinations in their bedrooms. Each unit had a clinical room but no dedicated examination room.

The layout of the approved centre provided opportunities for residents to engage in meaningful activities such as cooking and preparing food in the kitchen within the Tuke unit. The Pinel unit, a unit for male residents, had a public bar area. The internal garden between the Tuke and Pinel units had a Bus Stop and Post Office box.

The approved centre had addressed the issues of minimising hazards. The grounds and internal courtyards were well-designed with walkways and paved areas covered with soft synthetic material that provided protection to residents in the event of a fall. There were no remote or isolated areas of the approved centre so special monitoring was not required.

The approved centre was in a good state of repair externally and internally. A programme of general maintenance and decoration and comprehensive cleaning programme was in place. The approved centre looked clean and was free of offensive odours.

Where faults or problems were identified in relation to the premises, staff were aware of the established processes to report them. There were clearly-signed and easily accessible toilets and showers in the approved centre which were wheelchair-accessible with ample numbers of assisted bath and showers.

There was a sluice shared between two units. The approved centre provided designated cleaning rooms, a laundry room, and appropriately-sized lifts. Current national infection control guidelines were followed. There was a process for the checking and servicing of equipment and utilities. The approved centre had a back-up generator in place.

There was a risk management policy, a risk register and a Quality and Risk Committee with responsibility for identifying and managing ligature points and hazards within the organisation. All the units had anti-ligature door handles and windows in place. The approved centre had not carried out a ligature audit since 2015. Each individual resident had a completed risk assessment to monitor their risk level.

The approved centre was compliant with Regulation 22: Premises. It was not rated excellent as it was not in full accordance with the Processes, Training, and Monitoring pillars of the *Judgement Support Framework (JSF).*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

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

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

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

Inspection Findings

Processes: There was a written policy reviewed September 2016 in relation to the ordering, prescribing, storing and administration of medicines. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed to state that they had read and understood the policies relating to all aspects of medications. Staff were able to articulate the processes and procedures as set out in the policy. Nursing staff received annual training from the pharmaceutical supplier to the hospital. Each year staff underwent a competency test for medication administration.

The training records showed that not all staff received training on the importance of reporting medication incidents, or near misses. There were no records of doctors having received training in relation to the reporting of medication incidents.

Monitoring: There was an audit folder that showed quarterly audits of Medication Prescription and Administration Records (MPARs) being systematically undertaken for all units except the Hampstead unit. Analysis was completed to identify opportunities for improvement of medication management processes.

Evidence of Implementation: Fifteen Medication Prescription and Administration Records (MPARs) were inspected. In all cases the generic name of the medication was used and names of medications were written in full. There was dedicated space for routine, once-off and 'as required' medications. All medication was recorded. One MPAR did not have allergies or sensitivities to medication recorded. Three MPARs did not record the frequency of administration. One MPAR had no dosage specified. One MPAR had no administration route recorded. Two MPARs contained a prescription with no start date and five had no stop date recorded.

The expiration date of medication was not always checked prior to administration. One nurse administered three medications without checking the expiry dates. Hand hygiene practices were not always followed during the administration of medication. In eight out of fifteen MPARs, a doctor's Medical Council Registration Number (MCRN) was not recorded. One MPAR had a prescription that was altered but not rewritten.

One refusal of medication was recorded in the clinical file but not documented in the MPAR. The controlled drugs book contained a record of a drug being administered at 9.00 am by one nurse only. This was the only registered nurse on the ward at time of administration. The evening nurse co-signed the book on commencing the shift that evening.

Directions to crush medications was detailed on the front of the MPARs but was not specific to any particular medication being administered, potentially allowing for any prescribed medications to be crushed. Medication dispensed or supplied to the resident was not stored securely in locked storage and medication fridges were not locked. There was a pot of custard in the refrigerator where medication was stored. Resident property was stored in the controlled drugs press.

The door to the press where drugs were stored was unlocked and the keys had been left in the lock on the Domville unit. A staff member was informed of this. On return to the clinical room later that day, the key was still in door. A nurse was again informed who then promptly removed it. Another member of staff on a different unit, stated that it was routine practice to leave the key in the door as only nurses could access the clinical room. Later that day a chiropodist was tending to residents in the Domville clinical room without any nursing staff being present.

An inventory of medications was not conducted on a monthly basis on the rationale that due to limited stock, rotation was not possible or necessary.

The approved centre was found non-compliant with Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines for the following reasons:

a) Only one nurse was present to administer a controlled drug.
b) Allergies and sensitivities to medication were not systematically recorded in the MPARs.
c) Medication was not stored securely at all times.
d) MCRN numbers were missing in eight MPARs.
e) One refusal of medication was documented in the clinical file but not in the MPAR.
f) In one case a prescription was changed but not re-written.
g) The following prescription errors were noted: administration route of medication was not documented in one case, the dose of the medication was omitted in one case and the frequency of medication admission was not included in three cases.
h) The date of initiation and discontinuation for each medication was not always documented.
i) Food was stored in the medications refrigerator and property was stored in the controlled drugs press.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
		X	

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a written policy reviewed July 2015 available in relation to the health and safety of residents, staff and visitors within the approved centre. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a log to state that they had read and understood the policies with regard to health and safety. Staff were able to articulate an understanding of the processes relating to health and safety procedures.

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

Evidence of Implementation: There was a comprehensive Health and Safety statement and policy which clearly outlined the different personnel within the approved centre and their identified roles and responsibilities in relation to ensuring the health and safety of staff, residents and visitors.

The approved centre was compliant with Regulation 24: Health and Safety and given an Excellent quality assessment as it adhered to all aspects of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.25 Regulation 25: Use of Closed Circuit Television

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

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

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

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

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

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

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

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

Inspection Findings

CCTV was used solely for the purposes of security and not used for monitoring residents, therefore; it was assessed as non-applicable.

3.26 Regulation 26: Staffing

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy reviewed 15 January 2016 in relation to the approved centre's staffing requirements. It included the recruitment, selection and appointment process of the approved centre. It required that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents as well as the size and layout of the approved centre. It included ongoing staff training requirements and the frequency of training, and that all staff members be made aware of the provisions of the Mental Health Act (2001).

The policy did not include:

- The roles and responsibilities in relation to the recruitment, selection, vetting and appointment processes within the approved centre.
- The job description requirements.
- The required qualifications of training personnel.
- The evaluation of training programmes, both internal and external.
- The staff performance and evaluation requirements.
- The required content of staff personnel records.
- The use of agency staff.

Training and Education: Relevant staff had signed that they had read and understood the staffing policies and were able to articulate them.

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The number and skill mix of staff was not reviewed against the levels recorded in the approved centre's registration. There was an audit in relation to staffing and analysis was completed in reference to the *Judgement Support Framework* to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart that defined the leadership and management structure and the lines of authority and accountability of the approved centre's staff. Staff were recruited, selected and vetted, including permanent, contract and volunteers, in accordance to the approved centre's policy. References were sought and documented.

Staff rosters were available for the forthcoming fortnight and photocopies of previous ones were available from the summer months.

The number and skill mix of staffing was not sufficient to meet resident needs. At night there was one nurse and one Health Care Assistant on duty to provide care to 20 residents. When the nursing staff were taking a break, an appropriately qualified staff member was not on duty in the ward. Inspectors were unable to locate a nurse on Steele ward at one point during the inspection.

Staff had the appropriate qualifications, skills, knowledge and experience to do their job and records documenting this were available and showed that a mix of Registered General Nurses and Registered Psychiatric Nurses delivered the care and treatment to residents. A programme of training had been put in place since the previous inspection.

Not all staff had up to date training in Fire Safety, Management of Actual or Potential Aggression (MAPA), Cardiopulmonary Resuscitation (CPR) and the Mental Health Act. Some staff were trained in Manual Handling, Food Hygiene, Infection Control, Experiencing Dementia and Elder Abuse.

Outside trainers were contracted in to deliver specific training and two staff members were trainers in Management of Actual or Potential Aggression (MAPA). There were facilities and equipment available for staff in-service education and training.

The Mental Health Act 2001, the associated regulation and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were made available to staff throughout the approved centre.

The approved centre was non-compliant with this regulation because:

a) The number and skill mix of staff was not appropriate to the assessed needs of residents as required by the Regulation, part (2).
b) There was not always an appropriately qualified staff member on duty as required by the Regulation, part (3).
c) Not all staff were recorded as appropriately trained for their roles and responsibilities in terms of Mental Health Act (2001), MAPA, CPR or Fire Safety as required by the Regulation, part (4).

The following is a table detailing staff assigned to the approved centre.

Ward or Unit	***Staff Grade***	***Day***	***Night***
Tuke	RPN HCA	RPN x 2 HCA x 3	RPN x 1 HCA x 1
Ward or Unit	***Staff Grade***	***Day***	***Night***

Pinel	RPN HCA	RPN x 2 HCA x 3	RPN x 1 HCA x 1
Ward or Unit	***Staff Grade***	***Day***	***Night***
Steele	RPN HCA	RPN x 2 HCA x 1	RPN x 1 HCA x 1
Ward or Unit	***Staff Grade***	***Day***	***Night***
Domville	RPN HCA	RPN x 2 HCA x 1	RPN x 1 HCA x 1
Ward or Unit	***Staff Grade***	***Day***	***Night***
Farnham	RPN HCA	RPN x 2 HCA x 2	RPN x 1 HCA x 2
Ward or Unit	***Staff Grade***	***Day***	***Night***
Hampstead Clinic	RPN	RPN x 2	RPN x 2
Ward or Unit	***Staff Grade***	***Day***	***Night***
One member of staff floated across all units at night time.			
Ward or Unit	***Staff Grade***	***Day***	***Night***
	RCP	RCP x 2.3	RCP x1
	One additional Registered Nurse floated between the wards at night		
	Director of Nursing		
	Clinical Services Manager		
	CNM3		
	Senior House Officer		
	OT		
	2 x Night Nursing Officers (1 per night)		
	Psychologist		
	Social Workers WTE 0.8		
	Activity therapists WTE 2.3		
	Cognitive Behavioural Therapist 0.5		
Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA) Registered Mental Practitioner (RMP) *Registered Consultant Psychiatrist (RCP), Occupational Therapist (OT)*			
Non-Clinical Staff			
	Mental Health Act Administrator		
	Director of Operations		
	9 Housekeeping staff		
	2.5 x WTE Maintenance		
	6 x Household		
	0.5 x WTE Night Porter		
	4 X WTE Medical Secretaries		
	1 x Purchasing Manager		
	Quality and Risk Manager		
	Night porter		

	3 x WTE Human Resource Managers
	IT Manager
	3 x WTE Finance Managers
	Chaplain
	Housekeeping manager
	Receptionist

Other staff were accessible as required:

- Speech and Language Therapist
- Dietician
- Chiropodist
- Hairdresser
- Physiotherapist

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
		X	

3.27 Regulation 27: Maintenance of Records

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

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

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

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

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

Inspection Findings

Processes: There was a written policy reviewed March 2017 available in relation to the maintenance of records in the approved centre. The policy detailed the roles and responsibilities of staff in relation to the creation of, access to, retention of and destruction of records. The policy included authorised record retention periods and the process to be followed in order to correctly destroy records. General safety and security measures in relation to records were documented in the policy.

The policy did not specify the required resident record creation and content, nor did it outline the process to be followed for residents to gain access to their records.

The relevant legislative requirements relating to record maintenance; the implementation of the Data Protection Acts, Freedom of Information Acts and associated controls for records were not documented in the policy and record review requirements were omitted from the policy.

The policy did not specify the process to be followed in making a retrospective entry into resident records, nor did it outline the process to be followed in retaining inspection reports relating to: food safety, health and safety and fire inspections.

Training and Education: Staff had signed a log to state that they had read and understood the policies relating to maintenance of records. Staff were able to articulate the processes for the creation of, access to, retention of and destruction of records. Training records showed that not all of the clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy and ease of retrieval.

Evidence of Implementation: The records were stored together in a centralised location within each ward. Some of the records had loose pages and were not maintained in a logical order. Entries were factual and consistently written legibly in back ink. Each entry was followed by a signature. When as error was made, this was scored out with a single line and when student nurses wrote in the files their entries were countersigned by a registered nurse. Records did not always record the time of new entries using a twenty-four-hour clock.

The records were reflective of the residents' current status and the care and treatment being provided. Records in Pinel unit were stored in an unlocked press in the nurses' station which did not have a locked door. Loose pages were noted in four clinical files.

The approved centre was non-compliant with Regulation 27: Maintenance of Records as not all records were stored securely or in good order as required by the regulation part (1).

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	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

Not all information specified in Schedule 1 was included in the register. The register of residents was not up-to-date.

The approved centre was non-compliant with this regulation because it did not meet the minimum requirements of Schedule 1 to the Mental Health Act 2001.

	Compliant	Non-Compliant
Compliance with Regulation		X

Risk Rating			
Low	Moderate	High	Critical
		X	

3.29 Regulation 29: Operating Policies and Procedures

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

Inspection Findings

Processes: There was no written policy with regard to operating policies and procedures.

Training and Education: Staff were able to articulate the processes and procedures used in the approved centre. Staff signed a record to state that they had received and understood the operating procedures information. The approved centre was in the process of developing an electronic repository of all policies to include an electronic staff sign-in facility.

Monitoring: There was an annual audit with monthly meetings to review policy programme requirements. The programme was reviewed quarterly so there was also an ongoing audit. All analysis and findings were evaluated by the Quality and Risk Committee to approve any policy changes to be made.

Evidence of Implementation: The operating policies and procedures of the approved centre were developed by a committee in consultation with all relevant stakeholders. Some policies were generic to the service and others were only applicable to specific units in the approved centre. Where generic policies were used, there was a statement to clarify which aspect of the policy applied to each unit. There was a monthly policy committee meeting to check that obsolete policies were removed from circulation and placed in a central repository for old policies. The policy requirements were disseminated to each unit through the policy committee.

The policies were reviewed and escalated to the Quality and Risk Committee (QRC) for final approval. The format of the policies and procedures was standardised and kept in a Policies folder.

The operating policies and procedures required by the Regulations were all reviewed within the mandatory three years.

The approved centre was compliant with Regulation 29: Operating Policies and Procedures. It was not rated excellent as it was not in full accordance with the Processes pillar of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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: There was a written policy reviewed February 2016 available in relation to the facilitation of Mental Health Tribunals. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff had signed a log to state that they had read and understood the policy and were able to articulate the policy requirements.

Monitoring: An audit and analysis identified had been completed by the approved centre.

Evidence of Implementation: The approved centre had a private pod facility available for discussions with legal representatives and a Tribunal room in the Hampstead unit. Staff attended or participated in Mental Health Tribunals and provided assistance when needed.

The approved centre was compliant with Regulation 30. It was given an 'Excellent' rating as all elements of the *Judgement Support Framework* had been met.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.31 Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy reviewed February 2016 available in relation to the management of complaints. The policy was an inclusive Highfield Healthcare policy and referred to the approved centre, the Alzheimer's Care Centre and Elmhurst Nursing Home. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: Staff across Pinel, Farnham, Steele and Hampstead were trained in the complaints management processes. Staff had signed a log to state that they had read and understood the policy relating to complaints. Staff were able to articulate the processes for making, handling and investigating complaints as set out in the policy.

Monitoring: The complaints log provided a clear account of all complaints received to date in 2016. It included the nature of the complaint, the investigation, outcome, communication with the complainant and whether it was resolved to the satisfaction of those concerned.

Complaints data was analysed and reviewed by senior management. Required actions were identified and implemented to ensure continuous improvement of the complaints management process. The minutes of the Quality and Risk Committee showed that reviewing and resolving complaints was a standing item on their meeting agenda.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints. A consistent and standardised approach was implemented for the management of all complaints.

The methods to make a complaint included verbal, written, by email, telephone and through feedback or suggestions forms. Posters with complaints information and the names of two advocates available to the service were displayed throughout the approved centre. The Director of Nursing was the complaints officer and was based in the centre.

The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. The culture of the approved centre was to welcome feedback and to engage with any issues raised by residents or families. Complaints were treated as part of this process. Resident and family feedback on the experience of being an in-patient in the approved centre was sought through a formal survey process.

Minor complaints were addressed in community meetings and recorded in the minutes of the meeting. The complaints log contained details of complaints, as well as subsequent investigations and outcomes. They were fully recorded and kept separate from the resident's individual care plan. Complaints were dealt with in a timely manner. All complaints raised since the time of the last inspection had been resolved.

The approved centre was compliant with Regulation 31: Complaints Procedures and was given an 'Excellent' rating as it met all the elements of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	X			

3.32 Regulation 32: Risk Management Procedures

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

Inspection Findings

Processes: There was a written policy reviewed March 2016 available in relation to risk management. The policy included all the requirements necessary to fulfil the regulation.

Training and Education: Clinical staff had not received specific training on risk management, but had received risk management training as part of their general professional training. Staff were able to articulate the policy requirements.

The approved centre had a risk register with a comprehensive Health and Safety and Risk Management process. Staff demonstrated an understanding of risk management and the health and safety processes. Senior management had been formally trained in organisational risk management processes. The training log showed that not all staff were trained in incident reporting and documentation.

Monitoring: The risk register was audited at least quarterly to determine compliance with the approved centre's risk management policy. The approved centre had a risk register for each unit and the organisation also completed a risk management audit. Audit results were analysed and the approved centre was in the process of identifying new ways to improve processes and minimise risk.

Evidence of Implementation: Roles and responsibilities were clearly defined in relation to the management of risk and implementation of risk management policy. The registered proprietor was responsible for statutory liabilities and the multi-disciplinary teams (MDTs) were responsible for assessing individual resident's risk assessments.

A quality risk management team was responsible for the process of investigating, reviewing and monitoring incidents and met on a monthly basis. The team included a designated officer responsible for the completion of six-monthly incident summary reports. The approved centre used an approved risk rating framework which was recognised and approved by the Quality and Risk department of HSE. The approved centre was using Trend Analysis of incidents to minimise risks and incidents. All clinical risks identified were recorded and documented in the risk register for each unit.

The approved centre had not engaged in a ligature audit since the previous year's inspection but had undertaken structural refurbishments to minimise ligature points as far as was practicable. The windows and doors were anti-ligature.

A record of Mechanical Restraint (MR) showed that a risk assessment had been carried out prior to use. The clinical file held a full record of the episode. The clinical files had records of residents' risk assessments that were carried out during admission to, and transfer and discharge from, the approved centre. Risk was assessed in conjunction with medication requirements. The MDT also used a risk assessment tool to evaluate the risk to a resident who was absent without leave, potentially suicidal or in danger of self-harming, and accidental injury to staff and residents.

There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. It incorporated evacuation procedures.

The approved centre was compliant with Regulation 32: Risk Management Procedures. It was not rated excellent as it was not in full accordance with the Training and Evidence of Implementation pillars of the *Judgement Support Framework.*

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		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

Insurance cover included public liability, employer's liability, clinical indemnity and property. There was an indemnity scheme statement.

The approved centre was compliant with Regulation 33: Insurance.

	Compliant	Non-Compliant
Compliance with Regulation	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

There was an up-to-date Certificate of Registration prominently displayed in the approved centre. There were no conditions relating to the approved centre registration.

The approved centre was compliant with Regulation 34: Certificate of Registration.

	Compliant	Non-Compliant
Compliance with Regulation	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 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

Electro-Convulsive Therapy (ECT) was not used in the approved centre and this Rule was not applicable.

4.2 Section 69: The Use of Seclusion

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

Inspection Findings

Seclusion was not used in the approved centre and this Rule was not applicable.

4.3 Section 69: The Use of Mechanical Restraint

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

Inspection Findings

Processes: There was a written policy available in relation to the use of mechanical restraint (Part 5) in the approved centre. The policy did not specify the required frequency of training, nor did it identify appropriately qualified staff to provide the training.

Training and Education: There were no specific training records regarding the use of mechanical restraint. Not all staff had completed the Management and Prevention of Aggression and Violence (MAPA) training.

Evidence of Implementation: Five episodes of mechanical restraint were reviewed. In each case the reasons for the use of mechanical restraint were due to the risk of harm to the resident themselves. The resident's family and the Multi-Disciplinary Team (MDT) were involved in discussions regarding the type of mechanical restraint and conditions in which it would be used.

The approved centre had implemented a 'Safety Protocol Form for Mechanical Restraint for enduring self-harm' document that identified that less restrictive alternatives to mechanical restraint had been implemented without success in all five cases. The types of mechanical restraint were also documented on this form, as were the situations where this type of restraint was to be utilised for each individual.

The authorised duration of mechanical restraint was not specified in terms of time; instead the duration was documented as: 'when restless,' 'while sitting in chair,' or 'daytime.' In four cases the order for mechanical restraint was reviewed within the required three-month timeframe, however in one case the restraint was not reviewed for four months.

The approved centre was non-compliant with the Rule on Mechanical Restraint because:

a) The duration for mechanical restraint was not defined in five cases as required by the Rule, part 21.5 (e).
b) In one case, the order for mechanical restraint was not reviewed within the required three-month timeframe as required by the Rule on Mechanical Restraint, part 21.2.

	Compliant	Non-Compliant	
Compliance with Rule		X	
Risk Rating			
Low	Moderate	High	Critical
	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 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

There was one detained patient in the approved centre – this patient had been in continuous receipt of medication for over three months. The patient refused to sign the Consent for the Continuous Administration of Medication under Section 60 of the Mental Health Act 2001 - 17 (Treatment Without Consent Administration of Medicine for More than 3 Months

Involuntary Patient – Adult). A Form 17 was completed within the required timeframe and a copy of this form was kept in the patient's clinical file.

Following an assessment of the patient's ability to consent, two consultant psychiatrists approved and authorised treatment. The form was fully completed and the precise medication was recorded. Written information about the nature and purpose of the treatment was provided to the resident as was information about the likely benefits and adverse effects of the treatment. The treatment was in the patients' best interest.

The approved centre was rated compliant with regard to Consent to Treatment.

	Compliant	Non-Compliant
Compliance with Part 4	X	

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: There was a written policy reviewed April 2016 in relation to the use of Physical Restraint (PR). The policy was reviewed annually.

The policy included all required elements of the Code of Practice on the use of physical restraint.

Training and Education: There was a written record that staff had signed to say that they had read and understood the policy requirements. Thirty-two out of a total of 83 staff had completed Management of Actual and Potential Aggression (MAPA) training.

Monitoring: The use of physical restraint was reviewed annually.

Evidence of Implementation: There had been one episode of physical restraint in the approved centre since the previous inspection. A clinical practice form had been completed in one case and this stated that alternatives to physical restraint had first been considered in order to manage the unsafe behaviour. Next-of-kin were informed regarding the physical restraint and the duration of the physical restraint was not extended beyond the period necessary to prevent immediate and serious harm to self or others.

Physical restraint was initiated by Registered Psychiatric Nurses (RPNs) with a designated staff member as lead. The Consultant Psychiatrist (CP) was notified within three hours and the Registered Medical Practitioner (RMP) performed a medical examination on the resident.

The episode of physical restraint was not recorded in the resident's clinical notes. As a result, there was no record of the resident having been provided with the reasons for, the possible duration of the physical restraint or the circumstances that would lead to the discontinuation of the physical restraint. There was no record that the physical restraint was reviewed by the MDT within two days or that the resident had a chance to discuss the physical restraint with the MDT.

The approved centre was non-compliant because:

a) Not all staff were trained in the prevention and management of violence as required by the Code of Practice, part 10.1.
b) One episode of physical restraint had not been documented in the clinical notes in accordance with the requirements of the Code of Practice parts 5.7 (a).
c) There was no record of the resident having been provided with the reasons for, the possible duration of the physical restraint or the circumstances that would lead to the discontinuation of the physical restraint as required by the Code of Practice, part 5.8.
d) There was no record that the physical restraint was reviewed by the MDT within two days or that the resident had a chance to discuss the physical restraint with the MDT as required by the Code of Practice, part 9.3.

	Compliant	Non-Compliant	
Compliance with Code of Practice		X	
Risk Rating			
Low	Moderate	High	Critical
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

Children were not admitted to the approved centre and this Code of Practice was not applicable.

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 a risk management policy that covered the notification of deaths. The policy included all the requirements of the Code of Practice with the exception of the identified risk manager.

Training and Education: Staff had signed to state that they had read and understood the policies and were able to articulate them when asked.

Monitoring: Deaths were reviewed to identify and correct any problems as they arose and improve the quality of processes and procedures in place. All incidents were reviewed by the approved centre to identify any trends emerging.

Evidence of Implementation: The approved centre was compliant with Regulation 32, Risk Management as recorded in the policy document. There was an established incident reporting system in place. The approved centre used a standardised reporting form and this was available in the approved centre. A six-monthly summary of all incidents was sent to the Mental Health Commission as required. All deaths that had occurred since last inspection were notified to Mental Health Commission within 48 hours.

The approved centre was rated as non-compliant rating for this Code of Practice as the policy on risk management did not identify a risk manager as required by the Code of Practice part 4.2.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
X			

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

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

Inspection Findings

Processes: There were no specific policies relating to Persons Working in Mental Health Services with People with Intellectual Disabilities though the Admission Policy did reference communication protocols to ensure appropriate communication and close liaison with external agencies for people with an intellectual disability.

Training and Education: Information and communication sessions regarding the principles and guidance in the Code of Practice were delivered by external providers. The approved centre did not have a policy on the training of staff in the provision of care and treatment to people with intellectual disabilities in mental health services detailing the content covered by this training.

Monitoring: Due to the fact that no residents with an intellectual disability had been admitted since the previous inspection, the monitoring of this Code of Practice was not applicable.

Evidence of Implementation: There was no resident with an intellectual disability in the approved centre at the time of the inspection.

The approved centre was non-compliant with this Code of Practice as there was no policy describing the staff training in the provision of care and treatment to people with intellectual disabilities as required by the Code of Practice, part 6.2.

	Compliant	Non-Compliant	
Compliance with Rule		X	
Risk Rating			
Low	Moderate	High	Critical
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

Electro-Convulsive Therapy (ECT) was not used in the approved centre and this Code of Practice was not applicable.

6.6 Admission, 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:

Admission: There was a written policy in relation to the admission of residents. This policy was reviewed in June 2016. The policy included required elements of the Code of Practice with the exception of the protocols for timely communication with primary care and community mental health teams.

Transfer: There was a written policy in relation to transferring residents. This policy was reviewed in May 2016. The policy included required elements with the exception of the process to be followed in the case of transfer abroad.

Discharge: There was a written policy reviewed May 2016 in relation to discharging residents. Each resident was to be given a discharge pack which included follow up arrangements and a crisis plan. Follow up was required to take place three months post discharge. There were no details of the amount of frequency of follow-up care to be provided, nor was the manner for following up and managing missed appointments documented in the policy. The procedures for management of discharge against medical advice, the protocol for discharge of people with an intellectual disability and the protocol for discharge of older persons were not included in the policy.

Training and Education: Staff had signed to state that they had read and understood the policies.

Monitoring: There was a patient experience survey which evaluated the resident's experience of the admission and discharge processes in the approved centre.

Evidence of Implementation. The approved centre was compliant with Regulation 32: Risk Management and Regulation 20: Provision of information. The approved centre was non-compliant with Regulation 7 Clothing, with Regulation 15 Individual Care Plans and with Regulation 27 Maintenance of Records.

Admission: Each clinical file identified a key-worker and associate key-worker for each resident. The relevant key-worker names were displayed on a whiteboard in all the residential units. All the MDT records were kept together in the clinical file. Two admission records were selected for inspection. In both cases a Registered Medical Practitioner (RMP) had authorised the admission of the residents to the unit most appropriate to their needs. Both residents had admission assessments and these assessments were kept in the clinical file.

Transfer: The approved centre was compliant with regulation 18: Transfer of Residents. Two records of residents who had been transferred, were examined. In both cases, residents from the approved centre were transferred to a general hospital and the transfer was authorised by a Registered Medical Practitioner.

In both cases, the transfers were emergencies and the residents lacked capacity to consent to the transfers. Due to the urgency of transfer, next-of-kin were not consulted beforehand; this was documented. The nursing and medical members of the MDT were involved in the transfer process. A copy of the transfer letter was kept in the clinical files and signed by a Registered Medical Practitioner. The individual properties of both residents were managed on their behalf.

Discharge: A discharge pack was provided to each resident on discharge containing contact details, a crisis plan and a follow-up appointment for three-month post-discharge arranged by the resident's key-worker.

The discharge record for one resident was checked. An assessment of the resident with regard to mental and psychiatric state, risk and informational needs was conducted. The discharge was detailed in the resident's ICP. It included the date of discharge with records of communication with the Community Mental Health Team (CMHT).

The discharge meeting was attended by the resident, key-worker, relevant members of the MDT and member of family and was recorded in the clinical file. Efforts were made to contact the CMHTs of discharge within 24 hours. The discharge summary included the resident's diagnosis, prognosis, medication and risk issues.

The approved centre was not compliant with the Code of Practice: Admissions, Transfer and Discharge because:

(a) The approved centre was non-compliant with Regulation 15: Individual Care Plans.
(b) The approved centre was non-compliant with Regulation 27: Maintenance of Records.
(c) The policy on admission did not include the protocols for timely communication with primary care and community mental health teams.
(d) The policy on transfers did not make reference to transfers abroad.
(e) The policy on discharge did not address discharge against medical advice, the discharge of older people, or the discharge of people with an intellectual disability.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
	X		

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: Highfield Healthcare **Date submitted:** 10th February 2017

For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

Regulation 5: Food and Nutrition (inspection report reference 3.5)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. Residents' special dietary requirements were not taken into account as indicated by their individual care plans.	Corrective action(s): The two identified residents of the 110 residents now have MUST assessments completed. We have moved assessments onto our new patient information system. Post-holder(s): Director of Nursing	Review resident assessments on patient information system	Achievable	Complete
	Preventative action(s): Continue staff training in use of the MUST tool and policy awareness sessions. Care plan audit to ensure nutritional needs identified have appropriate interventions implemented. Post-holder(s): Director of Nursing	Training records, staff evaluation questionnaire Review resident assessments on patient information system	Achievable	31st March 2017

Regulation 6: Food Safety (inspection report reference 3.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
2. A high standard of hygiene was not maintained in relation to the storage of food as required by the Regulation part (1) (c).	Corrective action(s): A cleaning schedule for servery fridges and cutlery drawers has been put in place. Refridgerator temperatures are logged daily. Food temperatures will continue to be probed in the main kitchen. Post-holder(s): Director of Operations/ Catering Manager	Log books maintained.	Achievable	28th February 2017
	Preventative action(s): Routine audit of food hygiene to be carried out. Post-holder(s): Catering Manager	Hygiene audit	Achievable	Monthly/ quarterly

Regulation 13: Searches (inspection report reference 3.13)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
3. The registered proprietor did not ensure that staff and residents were aware of the policy and procedures on searching as required by the regulation part (5).	Corrective action(s): Policy awareness sessions will be held with staff at unit level. The resident guides now include details of searches. Post-holder(s): Director of Nursing/Clinical Services Manager	Training records, staff evaluation questionnaire.	Achievable	17th February 2017
	Preventative action(s): Policy awareness sessions will be held with staff at unit level. The resident guides include details of searches and residents and families are told verbally on admission. Post-holder(s): Director of Nursing/Clinical Services Manager	Training records, staff evaluation questionnaire.	Achievable	17th February 2017
4. Not all searches were documented.	Corrective action(s): All searches are documented. Post-holder(s): Director of Nursing/ Clinical Services Manager	Review patient files	Achievable	Complete
	Preventative action(s): Policy awareness sessions will be held with staff at unit level.	Training records, staff evaluation questionnaire.	Achievable	17th February 2017

	Post-holder(s): Director of Nursing/Clinical Services Manager			
5. In the case of the documented search, there was no evidence that the resident had been informed of the reasons for the search.	Corrective action(s): The search form was amended to explicitly state this provision. Post-holder(s): Director of Nursing	Review patient files	Achievable	Completed
	Preventative action(s): All residents will have this documented as per the search form and sign to affirm that this has been explained. Post-holder(s): Director of Nursing	Review patient files.	Achievable	In place.

Regulation 15: Individual Care Plan (inspection report reference 3.15)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
6. The ICPs in the Hampstead Unit were not contained in one composite set of documents.	Corrective action(s): The MDT weekly meeting review record is now held with the ICP and ICP review record in one place. Post-holder(s): Clinical Services Manager	Review ICP's	Achievable	Complete.
	Preventative action(s): The MDT record is now held with the ICP and ICP review records.	Audit ICP's	Achievable	Complete

	Post-holder(s): Clinical Services Manager.			
7. The ICPs in the residential units did not record MDT input to the development and review of the ICPs.	Corrective action(s): The new OT and physio now input into the ICP development and ICP reviews. Post-holder(s): Director of Nursing	Audit ICP's	Achievable	30th June 2017
	Preventative action(s): The new OT and physio now input into the ICP development and ICP reviews. Post-holder(s): Director of Nursing	Audit ICP's	Achievable	30th June 2017
8. Not all ICPs contained documented resources.	Corrective action(s): The ICP's will now include the staff members name in addition to their discipline who is responsible for providing the intervention. Post-holder(s): Director of Nursing	Audit ICP's	Achievable	30th June 2017
	Preventative action(s): An audit of all ICP's will take place to ensure that the individual responsible is identified and not just their discipline listed. Post-holder(s): Director of Nursing	Audit ICP's	Achievable	30th June 2017

Regulation 19: General Health (inspection report reference 3.19)				
Area(s) of non-compliance	**Specific**	**Measurable**	**Achievable/ Realistic**	**Time-bound**

	*Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	*Define the method of monitoring the implementation of the action(s)*	*State the feasibility of the action(s) (i.e. barriers to implementation)*	*Define time-frame for implementation of the action(s)*
9. In 17 cases the residents' general health assessments were not documented as completed within the previous six months.	Corrective action(s): All 17 residents had their health needs assessed and documented within the 6 month timeframe. We have in addition completed a full medical examination for each resident following inspection. Post-holder(s): Director of Nursing	Review medical records	Achievable	Complete
	Preventative action(s): The approved centre has GP's visiting daily who assess the general health needs of all residents and document this in their clinical files. Evidence of this was available at the time of inspection and records provided accordingly. We will however continue with the practice of routine medicals and a schedule for 2017 has been drawn up and given to our general practice. Post-holder(s): Director of Nursing	Review medical records	Achievable	Complete & ongoing

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines (inspection report reference 3.23)				
Area(s) of non-compliance	**Specific**	**Measurable**	**Achievable/ Realistic**	**Time-bound**
	Define corrective and preventative action(s) to address the non-	*Define the method of monitoring the*	*State the feasibility of the action(s) (i.e.*	*Define time-frame for*

	*compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	*implementation of the action(s)*	*barriers to implementation)*	*implementation of the action(s)*
10. Only one nurse was present to administer a controlled drug.	Corrective action(s): Issue rectified. The policy complies with legislation which is to have one nurse and one witness administer controlled drugs. Post-holder(s): Director of Nursing	Pharmacy quarterly audits, internal medication audits	Achievable	Complete
	Preventative action(s): One nurse and one witness signs the control book. Staff education and supervision to reinforce procedures along with internal and external audits. Post-holder(s): Director of Nursing	Pharmacy quarterly audits, internal medication audits	Achievable	Complete & ongoing
11. Allergies and sensitivities to medication were not systematically recorded in the MPARs.	Corrective action(s): An audit of all kardexes was carried out and all residents with allergies have this specified on their kardex. Staff education and supervision to reinforce procedures. Post-holder(s): Director of Nursing/ Pharmacy	Pharmacy quarterly audits, internal medication audits	Achievable	Complete
	Preventative action(s): The pharmacy assess this area in their quarterly audits. Post-holder(s): Pharmacy/ Director of Nursing	Pharmacy quarterly audits, internal medication audits	Achievable	Quarterly

12. Medication was not stored securely at all times.	Corrective action(s): Medication is stored in the locked clinical room at all times and this room has restricted access to nurses and medical professionals only. All medication presses in the clinical room are locked at all times. Post-holder(s): Directof of Nursing	Pharmacy quarterly audits, internal medication audits	Achievable	Complete.
	Preventative action(s): External and internal medication audits are carried out every quarter to ensure compliance. Post-holder(s): Stacks pharmacy and Director of Nursing	Pharmacy quarterly audits, internal medication audits	Achievable	Complete
13. MCRN numbers were missing in eight MPARs.	Corrective action(s): All kardexes will have the MCN on them. Post-holder(s): Clinical Director	Pharmacy quarterly audits, internal medication audits	Achievable	28th February 2017
	Preventative action(s): The design of the kardex has been changed to include MCRN's at the top of the kardex and eliminate the need for doctors to sign MCRN's each time thus reducing likelihood of omission. Post-holder(s): Director of Operations/ Pharmacy	Pharmacy quarterly audits, internal medication audits	Achievable	Quarterly
	Corrective action(s): Issue rectified. Post-holder(s): Director of Nursing	Internal audits, pharmacy quarterly audits	Achievable	Complete

14. One refusal of medication was documented in the clinical file but not in the MPAR.	Preventative action(s): Staff education and internal supervision to ensure appropriate completion of the MPAR. Post-holder(s): Director of Operations/ Stacks Pharmacy	Internal audits, pharmacy quarterly audits	Achievable	28th February 2017
15. In one case a prescription was changed but not re-written.	Corrective action(s): Issue rectified. The new kardex eliminates the need for transcription of kardexes. Post-holder(s): Director of Operations/ Stacks Pharmacy	Internal audits, pharmacy quarterly audits	Achievable	28th February 2017
	Preventative action(s): The new kardex eliminates the need for transcription of kardexes. Post-holder(s): Director of Operations/ Stacks Pharmacy	Pharmacy quarterly audits	Achievable	28th February 2017
16. The following prescription errors were noted: administration route of medication was not documented in one case, the dose of the medication was omitted in one case and the frequency of medication admission was not included in three cases.	Corrective action(s): An audit of all kardexes was completed to ensure full compliance. Post-holder(s): Director of Operations/ Pharmacy	Kardex audit	Achievable	Complete
	Preventative action(s): Continue staff training on medication management including supervision where deemed appropriate. Post-holder(s): Director of Nursing/ Head of Human Resources	Audit of kardexes	Achievable	Ongoing

17. The date of initiation and discontinuation for each medication was not always documented.	Corrective action(s): Doctors now sign and date all discontinuations of regular medication. Post-holder(s): Clinical Director/Consultant Psychiatrists	Audit of kardexes	Achievable	28th February 2017
	Preventative action(s): The new kardex includes the date of initiation of the medication on it. Post-holder(s): Pharmacy	Audit of kardexes	Achievable	28th February 2017
18. Food was stored in the medications refrigerator and property was stored in the controlled drugs press.	Corrective action(s): Issue rectified. All staff reminded to store food items and any other items separately in servery kitchen fridge. Post-holder(s): Director of Nursing/Clinical Services Manager	Staff informed	Achievable	Complete
	Preventative action(s): The pharmacy audits review this area. No instance of this was found on external audit in 2016. Post-holder(s): Director of Nursing	Pharmacy audit	Achievable	Quarterly

Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
19. The number and skill mix of staff was not appropriate to the assessed needs of residents as required by the Regulation, part (2).	Corrective action(s): A new break management system is being put in place for nights with an additional nurse. There are two nurses rostered on every unit by day. Post-holder(s): Head of Human Resources	Review headcount and cover at monthly management meetings	Feasible if staffing levels are maintained.	31st March 2017.
	Preventative action(s): Head count support is being put in place to ensure appropriate cover at all times. A nurse floater system will be put in place for nights. Post-holder(s): Head of Human Resources	Review headcount and cover at monthly management meetings	Feasible on successful continuous recruitment	31st March 2017.

20. There was not always an appropriately qualified staff member on duty as required by the Regulation, part (3).	Corrective action(s): A new break management system is being put in place. Qualified nurse present in the units with the additional nurse and supported by the night nursing officer. Post-holder(s): Head of Human Resources	Review headcount and cover at monthly management meetings	Achievable	31st March 2017.
	Preventative action(s): As above. Post-holder(s): Head of Human Resources		Achievable	31st March 2017.
21. Not all staff were recorded as appropriately trained for their roles and responsibilities in terms of Mental Health Act (2001), MAPA, CPR or Fire Safety as required by the Regulation, part (4).	Corrective action(s): Mandatory training will continue to be rolled out for all staff. The MAPA training programme which commenced in February 2016 will continue to be rolled out and priority given to nurses and care assistants working on high risk mental health units. In order to safeguard staff and residents, breakaway techniques training will be provided to other disciplines in the meantime. Post-holder(s): Head of Human Resources	Highlight at weekly ops meetings and monthly management meetings.	There are significant resource implications in trying to train all disciplines in MAPA (1 to 2 days training porgramme) especially those who rarely if ever use these techniques. We used physical restraint less than 5 times last year and no cases of mechanical restraint for our 110 residents as we consider restrictive practices a last resort.	30th September 2017.
	Preventative action(s): Training will be put on the TMS system enabling more regular monitoring of completion of mandatory training.	Review completion of mandatory training at monthly management meetings and monthly Quality & Risk	Significant resource implications as stated above.	30th September 2017.

	Post-holder(s): Head of Human Resources	Management Committee meetings.		

Regulation 27: Maintenance of Records (inspection report reference 3.27)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
22. Not all records were stored securely or in good order as required by the regulation part (1).	Corrective action(s): Issue rectified and files are secured in all units. Post-holder(s): Director of Nursing	Spotcheck	Achievable	Complete
	Preventative action(s): Records are being uploaded to a new patient information system, which will eventually eliminate paper files. Post-holder(s): IT Manager	Audit	Achievable	End of 2017

Regulation 28: Register of Residents (inspection report reference 3.28)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
23. Not all information specified in Schedule 1 was included in the register. The register of residents was not up to date.	Corrective action(s): Rectified. Electronic register now in place. Post-holder(s): Director of Nursing.	Register available for review	Achievable	Complete
	Preventative action(s): Register has also been uploaded to Epic system and is being customised to meet all the requirements of Schedule 1. Post-holder(s): IT Manager	Review IT system	Achievable	28th February 2017

Section 69: The Use of Mechanical Restraint (inspection report reference 4.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
24. The duration for mechanical restraint was not defined in five cases.	Corrective action(s): A new restraint form introduced early in 2016 for restraint for enduring self harm indicates duration as 24 hours/ night time/ meal- times. Following inspectors feedback, staff have been appraised of the need to specify as much as possible precise times of duration of intended use. Post-holder(s): Director of Nursing	Audit	Achievable	Complete and ongoing.
	Preventative action(s): Quarterly audit of use of mechanical restraint. Post-holder(s): Director of Nursing.	Audit	Achievable	Quarterly
25. In one case, the order for mechanical restraint was not reviewed within the required three-month timeframe.	Corrective action(s): This is not a requirement of Part 5 of the rules, however we are happy to review all uses of mechanical restraint under Part 4 on a quarterly basis. Post-holder(s): Director of Nursing	Audit	Achievable	Quarterly
	Preventative action(s): Put reminders on new patient information system when in place.	Audit	Achievable	End of 2017

	Post-holder(s): IT Manager			

Code of Practice: The Use of Physical Restraint (inspection report reference 3.7)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
26. Not all staff were trained in the prevention and management of violence as required by the Code of Practice, part 10.1.	Corrective action(s): As per item 22 Post-holder(s): Head of Human Resources			
	Preventative action(s): See item 22 Post-holder(s): Head of Human Resources.			
27. One episode of physical restraint had not been documented in the clinical notes in accordance with the requirements of the Code of Practice parts 5.7 (a).	Corrective action(s): Issue rectified. Post-holder(s): Director of Nursing		Achievable	Complete
	Preventative action(s): As restraint is so seldom used, we will continue to raise awareness amongst staff of the requirements of the code to maintain competency. Most staff would never have used restraint before in Highfield as it is not our practice. Periodic audits of use of physical restraint will continue to ensure all	Audit	Achievable	Ongoing

	areas in code of practice are addressed. Post-holder(s): Director of Nursing			
28. There was no record of the resident having been provided with the reasons for, the possible duration of the physical restraint or the circumstances that would lead to the discontinuation of the physical restraint as required by the Code of Practice, part 5.8.	Corrective action(s): This is the same instance referred to in item 27 so the same corrective and preventative actions are being taken. Post-holder(s): Director of Nursing/ Clinical Services Manager	Review clinical files and restraint forms.	Achievable	Ongoing
29. There was no record that the physical restraint was reviewed by the MDT within two days or that the resident had a chance to discuss the physical restraint with the MDT as required by the Code of Practice, part 9.3.	Corrective action(s): As per item 27. Post-holder(s): Clinical Services Manager	Review clinical files and restraint forms.	Achievable	Ongoing

Code of Practice: Notification of Deaths and Incident Reporting (inspection report reference 6.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
30. The policy on risk management did not identify a risk manager as required by the Code of Practice part 4.2.	Corrective action(s): Risk management policies are under review and a new suite of policies will be issued. Post-holder(s): Quality & Risk Manager Preventative action(s): New policy will address issue raised. Post-holder(s): Quality & Risk Manager	Approval of policy by Quality & Risk Management Committee	Achievable	28th February 2017

Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities (inspection report reference 6.4)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
31. There was no policy describing the staff training in the provision of care and treatment to people with intellectual disabilities as required by the Code of Practice, part 6.2.	Corrective action(s): Policy to be devised to address this issue. Post-holder(s): Policy Committee	Policy	Achievable	31st March 2017
	Preventative action(s): As above. Post-holder(s):			

Code of Practice: Admission, Transfer and Discharge (inspection report reference 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
32. The policy on admission did not include the protocols for timely communication with primary care and community mental health teams.	Corrective action(s): Review existing policy on admission, transfer and discharge. Post-holder(s): Policy Committee	Revised Policy	Achievable	31st March 2017
	Preventative action(s): Revise existing policy as appropriate. Post-holder(s): Policy Committee	Revised Policy	Achievable	31st March 2017
33. The policy on transfers did not make reference to transfers abroad.	Corrective action(s): As above, same policy. Post-holder(s): Policy Commttee		Achievable	31st March 2017
	Preventative action(s): As above, same policy. Post-holder(s):		Achievable	31st March 2017
34. The policy on discharge did not address discharge against medical advice, the discharge of older people, or the discharge of people with an intellectual disability.	Corrective action(s): As above, same policy. Post-holder(s): Policy Commttee		Achievable	31st March 2017
	Preventative action(s): As above, same policy. Post-holder(s): Policy Committee		Achievable	March 2017