St. Edmundsbury Hospital

ID Number: AC0057

2017 Approved Centre Inspection Report (Mental Health Act 2001)

St. Edmundsbury Hospital
Lucan
Co. Dublin

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
25 May 2016

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, CEO

Registered Proprietor Nominee:
N/A

Inspection Team:
Donal O'Gorman, Lead Inspector
Noeleen Byrne
David McGuinness

Inspection Date:
14 – 16 March 2017

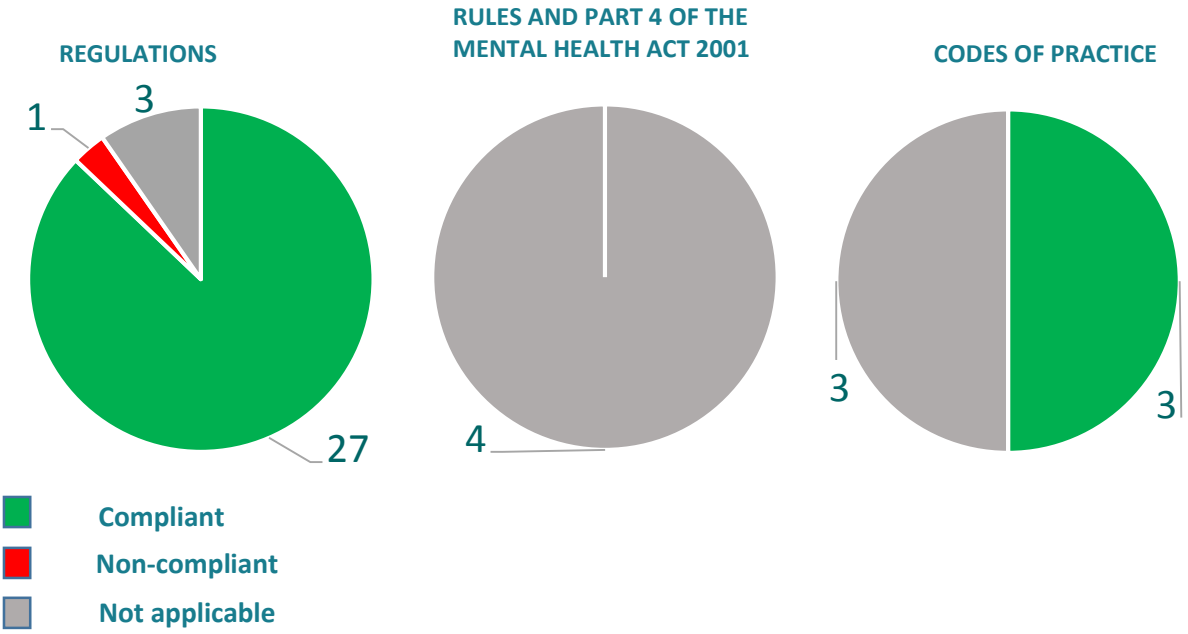
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
24 – 26 August 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
20th July 2017

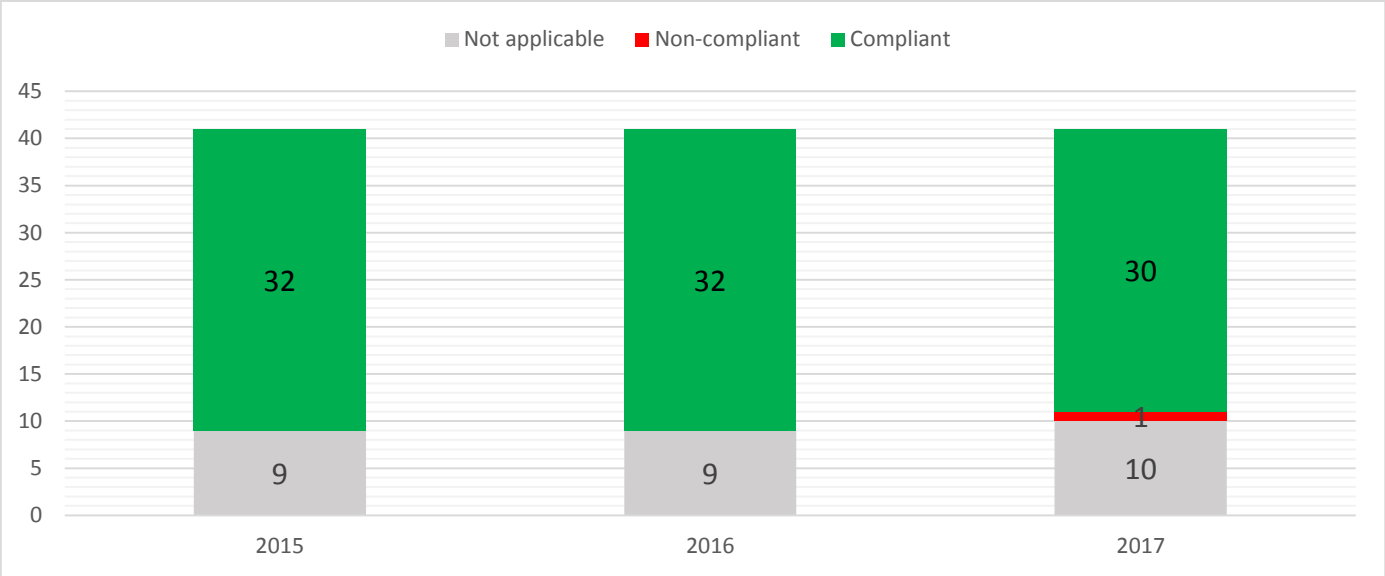
COMPLIANCE RATINGS



RATINGS SUMMARY 2015 – 2017

Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2015 – 2017

As there was no areas of non-compliance in 2015 and 2016, there were no risk ratings for these years.

Contents

1.0 Introduction to the 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.
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.

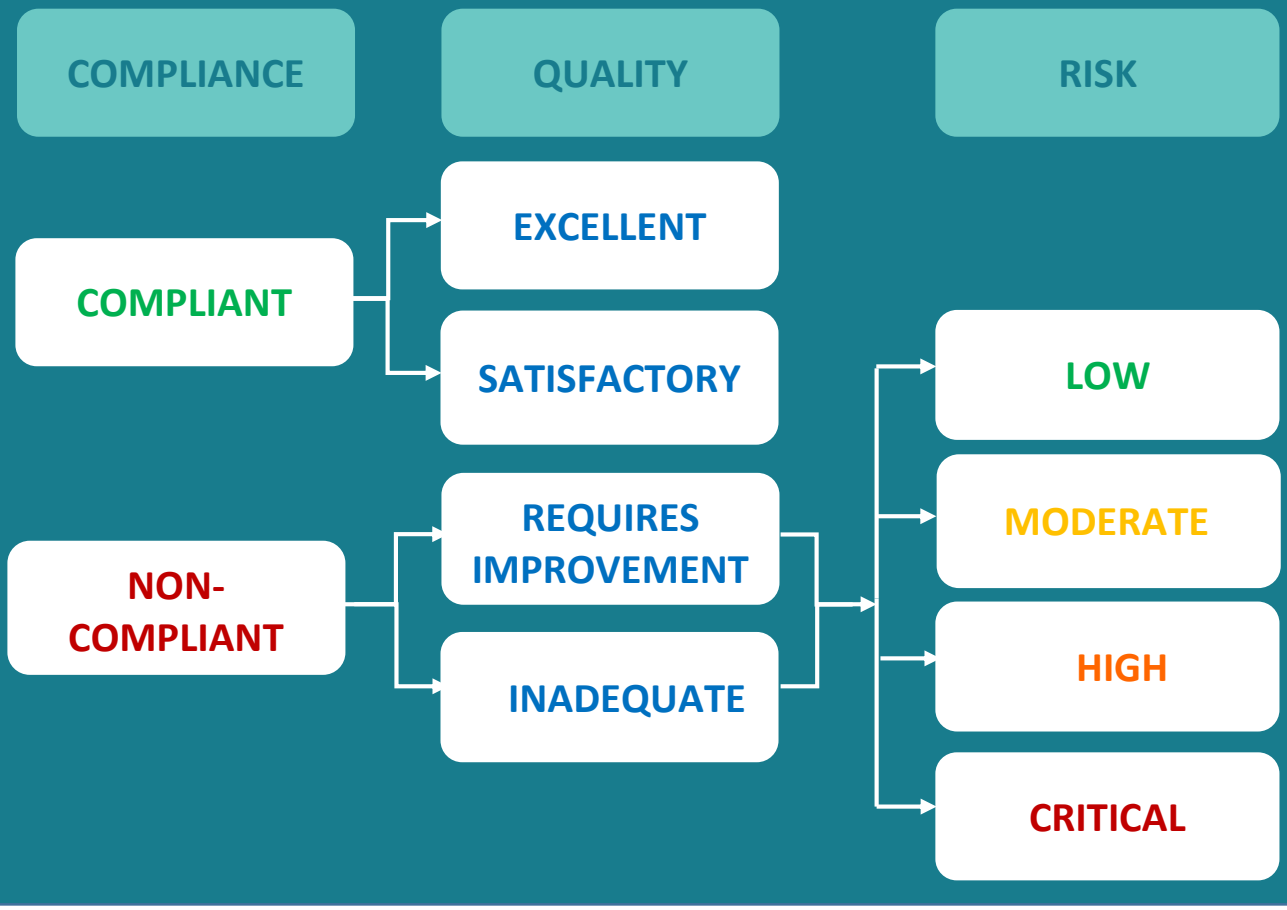
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will 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. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected. COMPLIANCE RATINGS are given for all areas inspected. QUALITY RATINGS are given for all regulations, except for 28, 33 and 34. RISK RATINGS are given for any area that is deemed non-compliant.



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 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated *Judgement Support Framework*, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

Safety in the approved centre

Identification of residents and food safety were both deemed excellent. Ligature anchor points were minimised. The number and skill mix of staff met resident's needs. The approved centre had excellent risk management policies and processes. There were multiple deficiencies in documentation of prescriptions and administrations of medication which had the potential to cause medication errors.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.

Appropriate care and treatment of residents

Residents in the approved centre received appropriate care and treatment. All residents had a multidisciplinary care plan that evidenced input from the resident. The provision of therapeutic services and programmes was excellent and outcomes were measured. General health access was also excellent. The process of transfer of residents to other facilities was in order. Clinical files were in good order with information easily retrievable. All elements of the Codes of Practice on admission, transfer and discharge were met. Residents were very complimentary of the care and treatment that was provided to them and the residents made reference to the very good nursing, medical, and occupational therapy care provided.

AREAS REFERRED TO
Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27, Part 4 of the Mental Health Act 2001, Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Rule Governing the Use of ECT, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.

Respect for residents' privacy and dignity

Respect for residents' privacy and dignity was excellent. The premises were laid out in a way that enabled residents to maintain privacy. Residents were encouraged to maintain their own property and possessions and residents' clothing was appropriate. Searches were carried out in a manner that was respectful of residents' privacy, dignity and gender and in accordance with the Regulation. CCTV was not used. There were no seclusion facilities.

AREAS REFERRED TO
Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Responsiveness to residents' needs

The approved centre was responsive to residents' needs. Food was nutritious and nicely presented. However, residents said that they would like more choice and options in relation to food and dessert menu. Residents had an excellent array of recreational activities. Religious and cultural beliefs and values were respected. Complaints were addressed and investigated and there was good information about the complaints process. There was excellent provision of information to residents about the approved centre, their illness and their medication. The premises were suitable for the residents' requirements.

AREAS REFERRED TO
Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Governance of the approved centre

St. Edmundsbury Hospital was part of St. Patricks Mental Health Services and came under the overall management of a board of governors established by charter. The direct operation of the hospital came within the competence of a senior management team. A detailed clinical and corporate governance structure was in place. There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rotas were in place, and the number and skill mix of staffing met resident needs. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. The clinical nurse manager 2 (CNM2) was in charge during the day and a nominated staff nurse was in charge for evenings and nights; out-of-hours support was provided by the assistant director of nursing in St. Patrick's University Hospital. Responsibilities were allocated at management level to ensure the effective implementation of risk management.

AREAS REFERRED TO
Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection

- Newly developed outdoor gymnasium area for residents' with eight exercise machines in place.
- The approved centre had upgraded and refurbished the residents' dining room area, including the catering facilities; the new dining room facilities can now accommodate all residents in one sitting.
- The communal area located beside the Resident Information Centre had been refurbished and upgraded with new sofas and couches purchased for the residents.
- The approved centre was installing an upgraded wireless Internet hub to ensure Wi-Fi was available throughout the building.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

St. Edmundsbury Hospital was located in the Lucan area of west Dublin and was situated in extensive open grounds with wooded parkland adjacent to the hospital. The hospital accommodation consisted of a converted 19th century dwelling house, used for dining, social, and therapeutic purposes, and an attached modern block, which contained accommodation for the residents. Accommodation was almost exclusively in single en suite rooms with a small number of twin rooms. The dining room and communal area beside the Resident Information Centre of the hospital had recently been renovated to provide a more welcoming experience for new residents.

St. Edmundsbury Hospital provided treatment for voluntary residents only. Therapeutic services and programmes were provided either on-site or in St. Patrick's University Hospital. The approved centre provided transport between St. Edmundsbury and St. Patrick's Hospitals to enable residents to attend therapeutic and recreational programmes in both locations.

The resident profile on the first day of inspection was as follows:

Resident Profile	
Number of registered beds	*52*
Total number of residents	51
Number of detained patients	0
Number of Wards of Court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0

4.2 Conditions to registration

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

4.3 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.

4.4 Governance

St. Edmundsbury Hospital was part of St. Patricks Mental Health Services and came under the overall management of a board of governors established by charter. The direct operation of the hospital came within the competence of a senior management team. A detailed clinical and corporate governance structure was in place. Minutes of all governance committee meetings, which included Clinical Council

meetings, senior staff meetings, Clinical Governance Committee meetings, and Risk & Safety Committee meetings, were provided to the inspectors. These indicated that a variety of governance issues were considered on a regular basis and that consideration of issues relating to St. Edmundsbury was integral to the governance structure.

5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 24 – 26 August 2016 indicated compliance with all relevant regulations, rules, and codes of practice.

5.2 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2016 and 2015:

Regulation/Rule/Act/Code	2015 Compliance	2016 Compliance	2017 Compliance
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines.	✓	✓	✗

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 13: Searches
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 22: Premises
Regulation 26: Staffing
Regulation 29: Operating Policies and Procedures
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

6.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engaged with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

With the residents' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

The inspection team met with five residents and received seven completed resident questionnaire leaflets during the course of the inspection. Residents were very complimentary of the care and treatment that was provided to them and the residents made reference to the very good nursing, medical, and occupational therapy care provided.

The issues raised from the resident meetings and completed resident questionnaires included:

- More regular laundry service.
- Smoking area not regularly cleaned.
- More resident participation and involvement with their treating multi-disciplinary teams**.**
- More choice and options in relation to food and dessert menu.
- Staff getting their meals before the residents, which can result in some items on the food menu not being available.

7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following:

- Director of Nursing
- Occupational Therapist
- Pharmacist
- Clinical Psychologist
- Clinical Audit Coordinator
- Registrar

8.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Consultant Psychiatrist X 2
- Director of Psychology
- Chief Executive Officer
- Medical Director
- Occupational Therapist
- Pharmacist
- Psychiatry Registrar
- Head of Social Work
- Programme Manager
- Director of Services
- Director of Nursing
- Nurse Practice Development Coordinator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The inspection team facilitated the risk manager and the nurse practice development coordinator with clarifying issues that had arisen during the inspection in relation to Regulation 23: Ordering, Storing, Prescribing and Administration of Medicines.

9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in November 2016. It included all of the elements of the *Judgement Support Framework.*

Training and Education: All relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Analysis had also been completed to identify opportunities for improving the resident identification process, and action points were identified.

Evidence of Implementation: An inspection of clinical files indicated that at least two of the following person-specific resident identifiers were used: name, date of birth, medical record number, and photographic ID. Two appropriate resident identifiers were used before the administration of medication, the undertaking of medical investigations, and the provision of health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. A caution stamp was used to alert staff to the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all the criteria of the *Judgement Support Framework*.

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was last reviewed in March 2015. It included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents received wholesome and nutritious food in accordance with their needs. A three-week menu cycle that changes twice a year was in place. Analysis was ongoing to identify opportunities for improving the processes for food and nutrition. This had resulted in the addition of healthy snacks to the vending machine in the approved centre. In December 2016, a healthy eating service user talk and cooking demonstration was held, followed by a questions and answers session and a walk.

Evidence of Implementation: Menus were nutritionally analysed by a dietician from Aramark. The service manager met with the dietician twice a year to review menus and requests. Residents were provided with a range of wholesome and nutritious food choices, including fresh fruit, vegetables, whole grains, and non-fat diary options. Vegetarian options were also available. Food was presented in an attractive and appealing manner, and hot meals – breakfast, lunch, and tea – were provided daily. Residents had access to tea and coffee making facilities up to midnight, after which nursing staff provided access to caffeine-free tea and coffee up to 06:00. Fresh water dispensers were available.

An evidence-based nutrition assessment tool was used and noted in individual care plans (ICPs). Nutritional and dietary needs were assessed and documented in the residents' clinical files. Weight charts were implemented, monitored, and acted upon, where appropriate. Where residents were identified as having special nutritional requirements, they were referred for review to the dietician in St. Patrick's University Hospital.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all the criteria of the *Judgement Support Framework*.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to food safety, which were last reviewed in July and December 2015. They included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed could articulate the processes for food safety, as set out in the policies. Food-handling staff had up-to-date training in the application of Hazard Analysis and Critical Control Points (HACCP). The training was documented.

Monitoring: Aramark, the catering company contracted to supply meals to the approved centre, had completed health and food safety audits. A goods inwards log and food temperature record were maintained. Analysis had been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: Staff handling food wore appropriate personal protective equipment, and the catering equipment was suitable and sufficient, with appropriate facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all the criteria of the *Judgement Support Framework*.

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in October 2016. It included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes in relation to residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. There was a repository of emergency clothing supplies, and a log of items issued to residents was maintained.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, and residents' clothing was observed to be clean and appropriate to their needs. An emergency supply of clothing was available, which took account of the residents' preferences, dignity, bodily integrity, and religious and cultural practices. No residents were observed wearing nightclothes during the day. All residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions, which was last reviewed in 2016. It included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to residents' property and possessions, as set out in the policy.

Monitoring: Personal property logs were maintained, monitored and available to the resident and analysis had been completed to identify opportunities for improving the processes around residents' personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre. They were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plans (ICPs). There was a safe in each bedroom, accessed via a keypad. Staff were on hand to help residents who needed help to activate their keypad code. Where the approved centre assumed responsibility for residents' property, personal effects were secured in a safe in the nurses' station. Two members of staff oversaw the process of providing residents with access to their monies. Signed records of the staff issuing the money were retained and, where possible, countersigned by the resident or their representative.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in August 2016. It also had a separate policy relating to the Twilight Programme, a series of social and recreational activities held in the evening and at weekends at St. Patrick's University Hospital. The policies included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed could clearly articulate the processes relating to recreational activities, as set out in the policies.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake/attendance. An audit had been completed to identify opportunities for improving the processes in relation to recreational activities.

Evidence of Implementation: Residents had access to appropriate recreational activities, and the available resources included reading materials, board and card games, walks in hospital grounds, TV, Internet, a snooker table, and table tennis. Recreational activities were scheduled in the approved centre on weekdays, and residents were facilitated in attending evening and weekend activities as part of the Twilight Programme in St. Patrick's University Hospital. There was also a scheduled Twilight Programme of recreational activities delivered in the approved centre on Wednesday evenings.

Recreational activities were developed, maintained, and implemented with resident involvement. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity, including a recently opened outdoor gym area with eight exercise machines. There were suitable indoor areas for recreation, including an arts and crafts room and a recreational room. Residents' decisions on whether or not to participate in activities were respected. Records of resident attendance at events were maintained.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in September 2015. The approved centre had adopted the HSE's *Intercultural Guide: Responding to the Needs of Diverse Religious Communities and Cultures in Health Care Settings.* The policy included all of the elements of the *Judgement Support Framework.*

Training and Education: All relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: An audit of the policy's implementation had been completed to ensure that residents' identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was reasonably practicable. A new multi-denominational room had been opened, a priest attended the approved centre once a week, and mass was celebrated on Sundays and holy days. A Protestant minister attended the approved centre, and all other faiths were catered for as required. Residents could also attend religious services outside of the approved centre, if deemed appropriate. The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in September 2015. The policy included all the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to visits, as set out in the policy.

Monitoring: Analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were displayed in the approved centre. There were a number of rooms suitable for visits, including areas where residents could meet visitors in private. One of the visiting rooms had a pool table, table tennis, and a selection of DVDs and board games. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Children were welcome but had to be accompanied by an adult and supervised all times. Visiting areas had facilities suitable for visiting children. There was no resident with visiting restrictions in place at the time of inspection.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in September 2015. It included all the elements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy on communication. Relevant staff were able to outline processes for facilitating residents' communication.

Monitoring: There was no documentary evidence that residents' communications needs and restrictions on communication were monitored on an ongoing basis. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to mail, telephone, fax and e-mail. Two computers with Internet access were provided for residents, who also had the use of a printer. A senior member of staff could examine resident communication only where there was reasonable cause to believe that the communication may result in harm to the resident or others. Following complaints about a lack of Wi-Fi in parts of the hospital, a new Internet hub was being installed.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in May 2015. It covered all of the elements of the *Judgement Support Framework.* This included requirements relating to the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she was accommodated.
- The consent of a resident regarding searches and the conducting of searches in the absence of consent.
- Dealing with illicit substances uncovered during a search.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff could detail the procedure for undertaking a search, with or without consent. The approved centre was in the process of switching to an online reporting process for searches, and ongoing staff training on the new system was in place.

Monitoring: A search log was available to the inspectors, and it indicated a process for systematically reviewing each search to ensure compliance with the requirements of the regulation. Documented analysis had been completed to identify opportunities for improving the resident search process.

Evidence of Implementation: The policy and processes relating to searches were communicated to all residents in the approved centre. A written record of every search of a resident and every property search was available, which detailed the reasons for the search, the names of the staff members who undertook the search, and details of who was in attendance during the search. Where illicit substances were uncovered during a search, policy requirements were implemented.

The written record relating to the search of a female resident was examined. A risk assessment was conducted in advance of the search, and resident consent was sought. The search, which was documented in the clinical file, was attended by at least two clinical staff and was implemented with due regard to the resident's dignity, privacy and gender. The resident was informed by those implementing the search of what was happening and why.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of written policies in relation to the care of the dying, dated 2015. These included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff could articulate the processes relating to end of life care, as set out in the policies. Given that no deaths had occurred since the date of the last inspection, the approved centre was not inspected against the monitoring and evidence of implementation pillars of the *Judgement Support Framework.*

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in September 2015. It included all of the elements of the *Judgement Support Framework.*

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed were able to clearly articulate the processes relating to individual care planning, as set out in the policy. Multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Quarterly ICP audits were conducted, and analysis had been completed to identify opportunities for improving the individual care planning process.

Evidence of Implementation: Seventeen residents' ICPs and clinical files were inspected. Each was a composite set of ring-bound documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. Each included details of goals, treatment, care required, and MDT reviews. The ICPs identified residents' assessed needs and the resources required to provide the care and treatment identified, however two of the ICP's examined did not include nor reflect the residents' reported needs.

Residents were initially assessed at admission and an ICP was drawn up by the MDT within seven days, following a comprehensive assessment. Evidence-based assessments were used where possible. A key worker was identified to ensure continuity in the implementation of an ICP. The ICP was reviewed weekly by the MDT in consultation with the resident, where possible. ICPs were updated, as indicated by residents' changing needs, condition, circumstances, and goals.

The clinical files contained evidence of family consultation in relation to ICPs, where appropriate. Residents were involved in the ICP process, had access to their ICPs, and were kept informed of any changes. There was documentary evidence that residents were offered copies of their ICPS. However, there was no evidence that a resident's refusal to accept a copy of his or her ICP was recorded.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the evidence of implementation pillar.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in September 2015. It included all of the elements of the *Judgement Support Framework.*

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents' assessed needs were met. Analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes and was documented by the head of social work.

Evidence of Implementation: The range of available, evidence-based programmes was appropriate to the assessed needs of the resident population, as outlined in individual care plans. Individual and group programmes included family therapy, addiction counselling, pharmacy, cognitive behavioural therapy, physiotherapy, psychotherapy, and psychological skills. Residents in transition had access to day services, including behavioural activation for depression, mindfulness, roles in transition, acceptance and commitment therapy, and self-esteem.

Brochures relating to the therapeutic services and programmes on offer were available in the approved centre. The programmes sought to restore and maintain optimal levels of physical and psychosocial functioning of residents. Where residents required a service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, and dedicated areas were available for individual and group therapies, including a reading room, treatment rooms, and an arts and crafts room. A log was maintained of residents' participation and engagement in and of outcomes achieved in therapeutic services or programmes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 17: Children's Education

NOT APPLICABLE

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

Given that the approved centre did not admit children, this regulation was not applicable.

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in March 2017. It included all of the elements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed a log indicating that they had signed the policy. Relevant staff interviewed could clearly articulate the processes for resident transfer, as set out in the policy.

Monitoring: The approved centre maintained a transfer log, and each record was reviewed to ensure that all relevant information was sent to the receiving facility. An audit had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of a resident who had been subject to an emergency transfer to a general hospital was examined. It contained evidence of the resident's consent to transfer and confirmed that a pre-transfer assessment had been completed, with details forwarded to the receiving facility. The file contained a letter of referral, including a list of current medications; a resident transfer form; and a list of required medications for the resident during transfer. During the emergency transfer, communications between the approved centre and the receiving facility were documented. The approved centre completed a checklist to ensure that the resident's records were transferred to the receiving facility, and copies of all relevant records were retained in the clinical file.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had several different policies in relation to the provision of general health care to residents, which were last reviewed in 2015. These included policies relating to GP primary care services, physical examinations and systems review, referral to an external or visiting physician, and medical management of service users. A medical emergency response policy was in place, which outlined the management, response, and documentation of a medical emergency, including cardiac arrest. Combined, the policies included all of the elements of the *Judgement Support Framework.*

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policies. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policies.

Monitoring: Residents had access to information on national screening programmes, but these were not a high priority in the approved centre because admissions were short term. A number of audits had been completed to identify opportunities to improve general health processes, including screening and assessments.

Evidence of Implementation: The approved centre had a resuscitation trolley, and staff had access to an Automated External Defibrillator; these were checked weekly.

The clinical files were inspected, and these contained comprehensive records relating to the assessment and treatment of residents' physical health. Residents had their full medical and general health needs assessed by a registrar on admission and were monitored on an ongoing basis during their admission period. Residents could access other general health services following a referral by their treating multi-disciplinary team. Records were maintained of residents' completed general health checks and the associated results. Residents also had access to information on national screening programmes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of policies in relation to the provision of information to residents. These included individual policies on the following: residents' access to communications facilities, available interpreter services, residents' orientation to a care setting, multi-disciplinary team (MDT) care planning and key workers, and service user and family education journey. There was also a literacy-friendly policy, a charter of residents' rights, and an information centre service plan. The policies included all of the elements of the *Judgement Support Framework.*

Training and Education: All staff had signed a log indicating that they had read and understood the policies. Staff interviewed could articulate the procedure for providing information to residents, as set out in the policies.

Monitoring: The provision of information to residents was audited on an ongoing basis to ensure it was appropriate and accurate. An audit had been completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission. The information booklet outlined available care and services as well as details of the housekeeping arrangements, mealtimes, personal property, complaints procedures, visiting times and arrangements, and relevant advocacy and voluntary agencies. Details of the MDT were provided to residents and their families at admission. Residents also received written and verbal information about their diagnosis, unless the provision of such information was potentially detrimental to their health and well-being. A variety of diagnosis and medication-related information, including risks and potential side-effects, was readily available, and medication information leaflets were in a format appropriate to residents' needs. The information was derived from evidence-based sources. Where necessary, residents had access to interpretation and translation services. All information provided to residents was documented in clinical notes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in September 2015. It included all of the elements of the *Judgement Support Framework.*

Training and Education: All staff had signed a policy log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: An annual audit was undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. From this, opportunities were identified to improve processes relating to resident privacy.

Evidence of Implementation: Residents were addressed by their preferred names. Staff were appropriately attired, spoke to residents in a friendly and respectful way, and sought permission before entering residents' rooms. All conversations relating to residents' clinical and therapeutic needs were handled with discretion.

The approved centre's layout and furnishings were conducive to resident privacy and dignity. There were 46 single rooms, all with en suite bathrooms. Bathroom doors had locks with an override facility. There were three double rooms with shared facilities, and appropriate screening was in place around the beds. Rooms were not overlooked by public areas and, where required, windows had appropriate screening. Residents were facilitated in making and taking private phone calls.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 22: Premises

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had multiple written policies in relation to different aspects of the maintenance and upkeep of the premises, which were last reviewed in 2016. The policies included all of the elements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed were unable to articulate the processes relating to the upkeep and maintenance of the premises.

Monitoring: The approved centre had undertaken and completed documented audits on hygiene, ligature points and risks, and safe disposal of sharps, among others.

Evidence of Implementation: The approved centre's physical environment provided an opportunity for residents to maintain and improve their mental and general health, with adequate indoor and convenient outdoor spaces available. Residents had access to personal space, including suitable accommodation, and to shared space in the form of appropriately sized and well-lit communal rooms. The physical structure and the overall approved centres' environment was well maintained and in good condition.

All communal and bedroom areas were adequately heated and ventilated. Heating was centrally controlled and temperature regulated and appropriate to meet residents' needs. Rooms were suitably sized and furnished to dampen excessive noise, and appropriate signage and sensory aids were provided to support residents' orientation. Hazards, including ligature points, were minimised.

The approved centre was in a good state of repair, inside and out. It had a maintenance manager who oversaw the programme of general maintenance. Maintenance issues were logged in a maintenance request log book and forwarded to the maintenance person on-site.

Out-of-hours maintenance tasks were dealt with by staff from St. Patrick's University Hospital. A cleaning schedule was in place, and current national infection control guidelines were followed. The facility was clean, hygienic, and free from offensive odours. The approved centre had adequate toilet and bathroom facilities, including assisted needs facilities, with at least one assisted toilet per floor. There were designated sluice and cleaning rooms, and laundry services were contracted out.

Residents' bedrooms were appropriately sized, and furnishings throughout the approved centre supported residents' independence, comfort, and needs. Dedicated examination rooms were available.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating Moderate

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of policies in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in 2016. There were separate policies on medication review and reconciliation, the return of medication to the pharmacy, pharmacy medication review, and therapeutic leave medication. The policies included all of the elements of the *Judgement Support Framework.*

Training and Education: All nursing and medical staff had signed a log indicating that they had read and understood the policies. Nursing and pharmacy staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policies. Staff had access to both written and electronic information on medications. All clinical staff (nursing, medical, and pharmacy) had received training on the importance of reporting medication incidents as part of their professional training. This was also covered in the approved centre's induction training.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policies and procedures and with the relevant legislation and guidelines. Medication incidents, errors, and near misses were recorded, and analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: A Medication Prescription and Administration Record (MPAR) was maintained for each resident, and 21 of these were inspected. Two appropriate resident identifiers were used when medication was being administered, and the Medical Council Registration Numbers of medical practitioners prescribing medication to residents were recorded. The allergy section was completed in each MPAR. Names of medications were written in full, and generic names were recorded where applicable. In two of the MPARs inspected, brand names of medications had been prescribed by the registrar. These were subsequently amended by the pharmacist, who replaced the brand name with the generic name in the MPAR.

The frequency of administration, the dosage, and the administration route for medications were recorded, as were the dates of initiation and discontinuation for each medication. Residents' medication was reviewed at admission, and the pharmacist was engaged in the medication reconciliation process. Medication was continually reviewed for residents at weekly meetings of the MDT, of which the pharmacist was a member. Medications were administered by a registered nurse or registered medical practitioner. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications, and a hand-hygiene audit had been completed. Controlled drugs were checked by two staff members against the delivery form and recorded in the controlled drug book.

There were twenty-two omissions observed in seven of the MPARs inspected: There was no signature to record whether these residents had received or refused medication or whether medication had been withheld. In one MPAR inspected, a medication order had not been re-written to reflect an alteration in the prescription. In another MPAR inspected, a member of nursing staff had signed to indicate that they had administered a dosage of medication that was different to the medication prescription.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a daily log of fridge temperatures was maintained. The medication trolley was locked and secured, and scheduled controlled drugs were secured separately. A system of stock rotation was in place. Medication dispensed to residents was stored securely, and an inventory of medications was completed weekly, with regular reconciliation and removal of old or unused medication undertaken by a pharmacist or pharmacy technician.

The approved centre was not compliant with this regulation because 7 of the 21 MPARs inspected had multiple omissions with regard to the recording of whether residents has received or refused medication or whether medication was withheld. This was an unsuitable practice under Regulation 23 (1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, which was last reviewed in June 2016. It included all of the elements of the *Judgement Support Framework.*

Training and Education: All staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy.

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

Evidence of Implementation: Regulation 24 was only assessed against the approved centre's written policies and procedures. Health and safety practices within the approved centre were not assessed.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NOT APPLICABLE

(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 any time on request.

INSPECTION FINDINGS

Given that closed-circuit television was not in use in the approved centre, this regulation was not applicable.

Regulation 26: Staffing

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had 70 written policies in relation to staffing, which were last reviewed in 2015. They covered all of the elements of the *Judgement Support Framework,* including the following:

- The roles and responsibilities relating to the recruitment, selection, vetting, and appointment of staff.
- Details of staff planning requirements.
- Information on staff rosters and their communication and the reassignment of staff.
- The training and orientation procedures for new staff, ongoing staff training requirements, frequency of training, and the required qualifications of training personnel.
- Job description requirements.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the staffing policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

Monitoring: The approved centre had a documented staff training plan that was updated annually. It included details of the number of skill mix of staff, and these were reviewed against the levels recorded in the approved centre's registration. Audits had been completed on the recruitment policy to determine whether the approved centre was compliant with the overall recruitment policy. There was documented evidence that analysis was completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rotas were in place, and the number and skill mix of staffing met resident needs. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. The clinical nurse manager 2 (CNM2) was in charge during the day and a nominated staff nurse was in charge for evenings and nights; out-of-hours support was provided by the assistant director of nursing in St. Patrick's University Hospital.

There was an up-to-date staffing plan, all staff had individual training plans, and all training was documented. Where agency staff were employed, they were subject to the same recruitment and vetting processes as regular staff. All health care professionals had received and completed up to date training in Fire Safety, Basic Life Support, and the Professional Management of Aggression and Violence, and the Mental Health Act (MHA) 2001. All nursing staff and the cognitive behavioural therapists had received training in Children First. All staff were trained in accordance with the assessed needs of the residents, and additional training had been delivered on manual handling, hand hygiene, hand-washing, risk management, and incident reporting. Staff reported that resources were available to them for further training and education. The MHA, the associated regulation, MHC rules and codes, and all other documentation and guidance were available.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM2	1	0
	RPN	5	3
	HCA	0	0
	Occupational Therapist x 3		
	Social Worker x 3		
	Psychologist x 3		
	Consultant Psychiatrist x 3		
	Registrar x 3		
	Pharmacist x 1		
	Family Therapist x 1		
	Cognitive Behavioural Therapists x 3		
	Programme Coordinator x 1		

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of up-to-date written policies in relation to the maintenance of records. They included all of the elements of the *Judgement Support Framework,* including policies and procedures relating to the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

Training and Education: All staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policies. All clinical staff were trained in best-practice record keeping at induction.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. No analysis had been conducted to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: Residents' records were observed to be securely stored, up-to-date, and in good order. They were developed and maintained in a logical sequence, and they were maintained appropriately, with factual, consistent, and accurate entries. Records were written legibly in black ink, and each entry noted the date and time using the 24-hour clock and was accompanied by a signature. Each resident had an individual file, and appropriate identifiers – medical record number, name, and date of birth – were in use. Records were reflective of the residents' current status and the care and treatment being provided. Resident records were accessible only to authorised clinical staff, who had sole authority to make entries in residents' records.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained/destroyed in accordance with legislative requirements and the approved centre's policy and procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up-to-date and contained all of the required information listed in Schedule 1 of the Mental Health Act 2001.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in September 2015. It included all of the elements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Staff had received training on approved operational policies and procedures, at induction. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit was undertaken to determine compliance with review time frames. Analysis had been completed by the Clinical Governance Committee to identify opportunities for improving the process of developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, and they were communicated to all relevant staff. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines. They were approved and reviewed within a three-year time frame. Obsolete versions of policies and procedures were removed from circulation. Policies and procedures were presented in a standardised format that included title, reference and version number, details of the document owner, date of implementation, and details of approvers and reviewers.

The approved centre was compliant with this regulation. The quality assessment was excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 30: Mental Health Tribunals

NOT APPLICABLE

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

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

INSPECTION FINDINGS

The approved centre did not admit patients on an involuntary basis and, consequently, this regulation was not applicable.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in March 2017. It included all the elements of the *Judgement Support Framework*.

Training and Education: Relevant staff had received training on the complaints policy and were trained on an ongoing basis, when a new policy was introduced. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy. All staff had signed a log indicating that they had read and understood the policy.

Monitoring: Audits of the complaints log were completed, and complaints data was analysed for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. Complaints received by phone, in writing, or through the suggestion box were logged. The ways in which residents and their representatives could lodge a complaint were detailed in the complaints policy. The approved centre's management of complaints was well publicised and accessible. The information booklet for residents outlined details of the complaints procedure. A notice containing the complaints officer's name and contact details was displayed above the comment and complaints box.

All complaints were documented, investigated promptly, and handled with sensitivity. Serious complaints were escalated to the complaints officer. Minor complaints were logged and dealt with appropriately. The quality of service, care, and treatment of a resident was not adversely affected by reason of a complaint being made, and complaints were used as the basis for quality improvement. Details of complaints, investigations, and outcomes were recorded and kept separately from the resident's individual care plan.

The approved centre was compliant with this regulation. The quality assessment was excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had an up-to-date written policy in relation to risk management procedures, which was supported by 41 other policies. It covered all the elements of the *Judgement Support Framework,* including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring of risks.
- Rating identified risks.
- Controlling resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Risk rating, recording, reporting, investigating, and learning from incidents involving residents.
- Responding to emergencies.
- Protecting children and vulnerable adults under the care of the approved centre.

Training and Education: Relevant staff, including clinical staff, had received training in risk management processes at induction, and this included organisational risk, incident reporting, and health and safety. All staff had signed a log indicating that they had read and understood the policies, and staff interviewed were able to articulate the risk management processes, as set out in the policies.

Monitoring: The risk register was audited at least quarterly to determine compliance with the approved centre's risk management policies and as part of the overall governance process. All incidents were documented using Actuarial Risk Assessment Tool forms and/or the Longitudinal Assessment of Suicide Risk and were subsequently risk-rated.

Evidence of Implementation: The approved centre did not have a designated risk manager but there was a nominated risk manager, who also had overall responsibility for monitoring the risk management

process for two other approved centres. Responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest level of risk, as was reasonable practicable. Clinical, corporate risks, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Structural risks, including ligature points, were removed or mitigated.

The approved centre had a separate policy in relation to the completion of risk assessments before and during the delivery of specialised treatments such as Electro-Convulsive Therapy. At admission, residents were clinically risk assessed, and the risk assessment was incorporated into their individual care plan. Multi-disciplinary teams had continuous input into the development, implementation, and review of individual risk management processes. Residents and/or their representatives were involved in the risk management processes.

Incidents were recorded and risk-rated using a standardised form – a Datix form – and six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. The approved centre had an emergency plan and policy and a separate policy in relation to evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed in a public place, in the main reception area.

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

NOT APPLICABLE

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

Given that Electro-Convulsive Therapy was not used in the approved centre, this rule was not applicable.

Section 69: The Use of Seclusion

NOT APPLICABLE

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

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

Section 69: The Use Mechanical Restraint

NOT APPLICABLE

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

Given that mechanical means of bodily restraint were not used in the approved centre, this rule was not applicable.

11.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 Consent to Treatment

NOT APPLICABLE

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

Given that there were no detained patients in the approved centre for a continuous period of three months, Part 4 – Consent to Treatment was not applicable.

12.0 Inspection Findings – 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.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint, which was last reviewed in September 2016. It met all of the requirements of this code of practice. The policy outlined responsibilities in relation to initiating and overseeing restraint processes. It documented procedures for the provision of information to residents undergoing restraint. The policy also provided information on staff training requirements, including the frequency of training, details of those who should receive training, areas to be addressed during training, and alternatives to the use of physical restraint.

Training and Education: All staff had signed a log indicating that they had read and understood the policy. A record of staff attendance at training on the use of physical restraint was maintained. Restraint was never used to ameliorate staff shortages.

Given that the approved centre did not use physical restraint and no episode of restraint had occurred since the 2016 inspection, it was not assessed under monitoring and evidence of implementation.

The approved centre was compliant with this code of practice.

Admission of Children

NOT APPLICABLE

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

Given that the approved centre had a policy of not admitting children, this code of practice was not applicable.

Notification of Deaths and Incident Reporting

COMPLIANT

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 written policies in relation to the notification of deaths and incidents to the Mental Health Commission (MHC): the risk management policy and death of a service user in care policy. The policies met all of the requirements of this code of practice. These specified a risk manager and identified the roles and responsibilities of members of staff in relation to the reporting of deaths and incidents, including the completion of death notification forms, submission of forms to the MHC, and completion of six-monthly incident summary reports.

Training and Education: Staff had signed a log indicating that they had read and understood the policies. Staff interviewed were able to articulate the processes relating to notification of deaths and incidents, as set out in the policies.

Monitoring: No deaths had occurred in the approved centre since the 2016 inspection. A governance process was in place in relation to the notification of deaths and incidents.

Evidence of Implementation: The approved centre was compliant with Regulation 32: Risk Management Procedures, and it had an incident reporting system in place. A standardised incident report form was used, and a six-monthly summary of all incidents was provided to the MHC.

The approved centre was compliant with this code of practice.

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

NOT APPLICABLE

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

INSPECTION FINDINGS

The approved centre did not admit people with both an intellectual disability and mental illness and, consequently, this regulation was not applicable.

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

NOT APPLICABLE

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

Given that Electro-Convulsive Therapy was not used in the approved centre, this code of practice was not applicable.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate policies in relation to admission, transfer, and discharge. Together, these met the requirements of this code of practice.

Admission: There were separate policies for planned and involuntary admission, which referenced pre-admission assessments, eligibility for admission, and referral letters. The protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams were detailed. The roles and responsibility of multi-disciplinary team (MDT) members in relation to post-admission assessments were included. There was also a policy on privacy, confidentiality, and consent.

Transfer: The transfer policy, dated March 2017, detailed how a transfer is arranged, contained provisions for an emergency transfer, and referenced the safety of residents and staff during transfers. It defined the roles and responsibilities of staff in relation to the transfer of residents, and it included procedures for involuntary transfers and the transfer of a resident abroad.

Discharge: The discharge policy, dated October 2016, included procedures for the discharge of voluntary and involuntary residents, homeless people, older persons, and people with an intellectual disability. It contained information on prescriptions and the supply of medication on discharge and details of follow-up care, including relapse prevention strategies, crisis management, roles and responsibilities of staff in providing follow-up care, the level of follow-up contact required by residents, the following up and managing of missed appointments, and discharge against medical advice.

Training and Education: All staff had signed a log indicating that they had read and understood the policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission and discharge policies.

Evidence of Implementation:

Admission: The file of one resident admitted to the approved centre was examined. The admission, following a self-referral, was made on the basis of mental illness or disorder, and the decision to admit was taken by a registered medical practitioner (RMP). A comprehensive admission assessment was completed, and details of all assessments and examinations were included in the clinical file.

The approved centre's admission process was compliant with Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, Regulation 27: Maintenance of Records, and Regulation 32: Risk Management Procedures.

Transfer: The file of one resident who was transferred to another facility for specialised treatment was examined. The decision to transfer was made by the RMP and documented, and it was agreed with the receiving facility. An assessment of the resident was completed before the transfer, and efforts were made to respect the resident's wishes and obtain consent. MDT input into the transfer was in the form of nursing and medical involvement, and a family member/carer/advocate was involved in the transfer process. A letter of referral was retained in the resident's file. The approved centre's transfer process was compliant with Regulation 18: Transfer of Residents.

Discharge: The files of three residents who had been discharged from the approved centre were examined. In each case, the decision to discharge was made by an RMP, and a comprehensive assessment was completed prior to discharge and documented. All of the files indicated family consultation, risk assessment and management, and follow-up planning. Discharge meetings were held, and each discharge was coordinated by the relevant key worker. There was appropriate input into the process from the MDT, and communication with the primary care/community mental health teams was documented.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

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

Report reference: Pages 38 - 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. Seven of the 21 MPARs inspected had multiple omissions with regard to the recording of whether residents has received or refused medication or whether medication was withheld	New	Corrective Action(s): All MPAR's were checked for completeness and omissions.	Checking of MPAR's implemented by nursing staff under the supervision of the Clinical Nurse Manager 2.	There were no barriers to the implementation of this corrective action.	April 2017
		Preventative Action(s): All nursing staff will continue to be oriented to the requirement to record whether service users have received or refused medication or whether medication was withheld as per policy "CLIN 0009: Prescribing, Administration and Storage of Medicines including Medicines Controlled by the Misuse of Drugs Act". All nursing staff will sign to verify that they have understood the contents of this policy and their responsibility therein. An additional audit process will be set up to monitor compliance with the requirement for the recording of administration of medication. This will involve daily checks over a set period of time. Actions will be agreed and implemented commensurate with the audit findings. Post-Holder(s) responsible: Mr John Flaherty, Director of Nursing.	Policy Training/re-orientation provided by the Director of Nursing and Clinical Nursing Manager 2 in association with the Nurse Practice Development Coordinator. Audit to be conducted under the supervision of the Director of Nursing and the Clinical Nursing Manager 2	There are no barriers to the implementation of this corrective action. There are no barriers to the implementation of this corrective action	Q2 2017 Q 2 2017.

[1] Area of non-compliance reoccurring from 2016
[2] Area of non-compliance not reoccurring from 2016