**Mental Health Commission**

**Approved Centre Inspection Report**

*(Mental Health Act 2001)*

<table>
<thead>
<tr>
<th><strong>APPROVED CENTRE NAME:</strong></th>
<th>Acute Psychiatric Unit, Cavan General Hospital</th>
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</thead>
<tbody>
<tr>
<td><strong>IDENTIFICATION NUMBER:</strong></td>
<td>AC0019</td>
</tr>
<tr>
<td><strong>APPROVED CENTRE TYPE:</strong></td>
<td>General Adult Psychiatry</td>
</tr>
<tr>
<td><strong>REGISTERED PROPRIETOR:</strong></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td><strong>REGISTERED PROPRIETOR NOMINEE:</strong></td>
<td>Mr Leo Kinsella</td>
</tr>
<tr>
<td><strong>MOST RECENT REGISTRATION DATE:</strong></td>
<td>1 March 2014</td>
</tr>
<tr>
<td><strong>NUMBER OF RESIDENTS REGISTERED FOR:</strong></td>
<td>25</td>
</tr>
<tr>
<td><strong>INSPECTION TYPE:</strong></td>
<td>Unannounced</td>
</tr>
<tr>
<td><strong>INSPECTION DATE:</strong></td>
<td>14, 15, 16 December 2015</td>
</tr>
<tr>
<td><strong>PREVIOUS INSPECTION DATE:</strong></td>
<td>3 and 4 June 2014</td>
</tr>
<tr>
<td><strong>CONDITIONS ATTACHED:</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>LEAD INSPECTOR:</strong></td>
<td>Ms Lisa Kiernan</td>
</tr>
</tbody>
</table>
| **INSPECTION TEAM:** | Ms Lydia Martin  
| | Mr Liam Hennessy                              |
| **THE INSPECTOR OF MENTAL HEALTH SERVICES:** | Dr Susan Finnerty MCN009711 (Acting)           |
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1.0 Mental Health Commission Inspection Process

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person,

b) See every patient the propriety of whose detention he or she has reason to doubt,

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder, and

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

Each approved centre shall be assessed against all regulations, rules, codes of practice and Section 4 of the Mental Health Act 2001 at least once on an annual basis. Inspectors shall use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined the individual regulation, or rule, shall also be risk assessed.

The approved centre is required to act on all aspects identified as non-compliant or with a high / critical risk rating. Demonstration of immediate corrective rectifications, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and time-bound. All actions must have identified timeframes and responsibilities.

A copy of the draft report was forwarded to the service and comments and review on the report were invited from the Registered Proprietor. These comments were reviewed by the lead inspector and incorporated into the report, where relevant.

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health Commission has the authority to initiate escalating enforcement actions up to, and
including, removal of an approved centre from the Register and the prosecution of the Registered Proprietor.
2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

The approved centre was located within Cavan General Hospital on the lower ground floor. It was a 25-bed acute psychiatric unit. The approved centre, although not purpose-built, was spacious, bright and wheelchair accessible. Sleeping accommodation comprised single rooms and four and six-bed dormitories. It had recently been painted throughout, with the addition of numerous brightly painted murals conveying a recovery-focused theme. There was an allocated family room, an occupational therapy (OT) room, an OT kitchen and a gym accessible to residents, as well as adequate communal space and an outdoor courtyard.

Two consultant psychiatrist-led multidisciplinary teams provided care and treatment for residents, including acute psychiatric care and psychiatry of later life. In total, there were 19 residents in the approved centre during the inspection. There were four female and eight male patients detained under the Mental Health Act 2001 (MHA).

2.2 Governance

The approved centre was part of the overall governance structure in Cavan/Monaghan Mental Health Services. Minutes of the Area Mental Health Management meetings were made available to the inspection team and reviewed. They addressed service provision and service development. The Patient Quality and Safety group meetings, previously known as the Clinical Governance Working group, addressed health and safety issues and risk management on an ongoing basis. Meetings were held regularly and attended by operational and clinical management staff and service users.

2.3 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against with the exception of the following, which were not applicable:

- Regulation 17 – Children’s Education
- Regulation 25 – Use of Closed Circuit Television
- Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint
- Rules Governing the Use of Electro-convulsive Therapy
- Code of Practice on the use of Electro-convulsive Therapy for Voluntary Patients

The inspection was undertaken onsite in the approved centre on:

14 December 2015 09:00 – 18:00
15 December 2015 09:00 – 18:00
16 December 2015 10:00 – 16:00
2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 3 and 4 June 2014 identified the following areas that were not fully compliant:

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Inspection Findings 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 9 – Recreational Activities</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 11 – Visits</td>
<td>Compliant</td>
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<tr>
<td>Regulation 15 – Individual Care Plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16 – Therapeutic Services and Programmes</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21 – Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22 – Premises</td>
<td>Compliant</td>
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<tr>
<td>Regulation 23 – Ordering, Prescribing, Storing and Administration of Medication</td>
<td>Compliant</td>
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<tr>
<td>Regulation 26 – Staffing</td>
<td>Non-Compliant</td>
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<tr>
<td>Regulation 27 – Maintenance of Records</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 32 – Risk Management Procedures</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-convulsive Therapy</td>
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<tr>
<td>Rules governing the Use Mechanical Means of Bodily Restraint</td>
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<tr>
<td>Code of Practice on the Use of Physical Restraint</td>
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<tr>
<td>Code of Practice on the Admission of Children</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Notifications of Deaths and Incident Reporting</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge</td>
<td>Compliant</td>
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<tr>
<td>Code of Practice on the Use of Electro-convulsive Therapy for Voluntary Patients</td>
<td>Not Applicable</td>
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2.5 Conditions to Registration

In 2014, the following condition was attached to the registration of the Acute Psychiatric Unit, Cavan General Hospital:

The Mental Health Commission requires notification in writing when a programme of electro-convulsive therapy (ECT) is prescribed for a patient or resident by the responsible consultant psychiatrist. The notification must be made prior to the administration of this programme and must include the following:

(i) The proposed date of commencement of the programme of ECT;
(ii) Confirmation that the requirements of Section 11: Staffing of the Rules Governing the Use of Electro-Convulsive Therapy or Section 12: Staffing of the Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, as applicable, will be fully complied with throughout the administration of the programme of ECT; and
(iii) Confirmation that all staff members who will be involved in the administration of the programme of ECT have completed an induction programme.

Date attached: 19th August 2014
2.6 Non-compliant areas on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>Risk Rating</th>
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<tbody>
<tr>
<td>Regulation 21 – Privacy</td>
<td>Low</td>
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<td>Regulation 26 – Staffing</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 27 – Maintenance of Records</td>
<td>High</td>
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<tr>
<td>Regulation 32 – Risk Management Procedures</td>
<td>Low</td>
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<tr>
<td>Part 4 – Consent to Treatment</td>
<td>Moderate</td>
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<tr>
<td>Code of Practice on the Use of Physical Restraint</td>
<td>High</td>
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<tr>
<td>Code of Practice on Admission of Children</td>
<td>Moderate</td>
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The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these are included in the report, in the relevant areas.

2.7 Areas of compliance rated Excellent on this inspection

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<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
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<tr>
<td>Regulation 11 – Visits</td>
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<td>Regulation 24 – Health and Safety</td>
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<td>Regulation 28 – Register of Residents</td>
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<tr>
<td>Regulation 30 – Mental Health Tribunals</td>
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<td>Regulation 31 – Complaints Procedures</td>
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<td>Regulation 33 – Insurance</td>
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<tr>
<td>Code of Practice on the Notification of Deaths and Incident Reporting</td>
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<tr>
<td>Code of Practice on Admission, Transfer and Discharge</td>
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2.8 Areas of good practice identified on this inspection

- Staff were observed throughout inspection to treat residents with dignity and respect. Their manner and demeanour was professional.
- A Strategic Framework 2015 – 2020 was developed for Cavan Monaghan Mental Health Services to advance national goals from *A Vision for Change* and reflected overall commitment at senior management level to excellent service provision in line with national best practice guidelines.
- The approved centre had embraced the recovery ethos and demonstrated commitment to further develop this principle. An artist had painted murals throughout the approved centre with many recovery-orientated messages which created a positive atmosphere.
- A new Medication Prescription Administration Record was introduced and the standard of prescribing was high, as described in the report under Regulation 23.
- A multi-task attendant was employed to assist with the current skill mix, the delivery of care and the provision of recreational activities in the approved centre.
2.9 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. There had been no incidents of sepsis, MRSA or clostridium difficile in the approved centre since the previous inspection in 2014. The approved centre had access to an infection control nurse based in Cavan General Hospital for advice around the management of such issues arising.

2.10 Resident Interviews

A number of residents were interviewed throughout the course of inspection. Residents spoke highly of staff and the therapeutic support they received. They were all aware of their care plan and reported that they felt involved and able to actively participate in their treatment.

2.11 Feedback Meeting

A feedback meeting was held on Wednesday 16 December 2015 at 15:00 to present initial findings and offer opportunity for any clarification arising. This meeting was attended by –

- Acting Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Service User Representative
- Business Manager
- Quality and Patient Safety Manager
- Occupational Therapy Manager
- Senior Occupational Therapist
- Principal Social Worker
- Principal Psychologist

A number of clarifications were provided regarding aspects of the inspection process and were incorporated into this report.
### 3.0 Inspection Findings and Required Actions - Regulations

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

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

<table>
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<tr>
<th>3.1 Regulation 1: Citation</th>
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<tbody>
<tr>
<td>3.2 Regulation 2: Commencement</td>
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<td>3.3 Regulation 3: Definitions</td>
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</table>
3.4 Regulation 4: Identification of Residents

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

**Inspection Findings**

*Processes:* The approved centre had processes in place for identifying residents for medication and therapeutic purposes. There was a process in place for similar or same-named residents.

*Training:* Staff were aware of their roles and responsibilities in relation to identifying residents. Staff were trained as part of their initial induction to the approved centre.

*Monitoring of Compliance:* There was no documented audit on the process of identification of residents.

*Evidence of Implementation:* At least two unique identifiers were used when identifying residents. Each resident’s clinical file had a unique identification number with a name and date of birth. A sticker was used on clinical documents to alert staff of similar or same-named residents.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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### 3.5 Regulation 5: Food and Nutrition

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

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

**Inspection Findings**

**Processes:** There were defined processes in place in relation to food and nutrition. There were procedures in place to ensure the provision of food and drink to residents in quantities adequate for their needs.

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

**Monitoring of Compliance:** There was no documented audit on the process. Residents’ weights were monitored weekly and dietary intake charts were used to monitor intake when required.

**Evidence of Implementation:** The approved centre had access to a dietician, if required. Where appropriate, nutritional and dietary issues were reviewed within the individual care plan. Residents had a choice of hot meals daily. Dietary preferences in relation to religious beliefs were accommodated. Healthy options and special diets were catered for as required. There was a ready supply of drinking water available to residents. Hot and cold drinks were provided at regular intervals throughout the day.

**Compliance Rating:**

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<tr>
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3.6 Regulation 6: Food Safety

(1) The registered proprietor shall ensure:
(a) the provision of suitable and sufficient catering equipment, crockery and cutlery
(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:
(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
(c) the Food Safety Authority of Ireland Act 1998.

Inspection Findings

Processes: There were defined processes in place in relation to food safety. Meals were prepared in the main kitchen in the hospital and brought to the approved centre in a temperature-regulated trolley.

Training: Relevant staff received Hazard Analysis and Critical Control Points (HACCP) training.

Monitoring of Compliance: There was evidence that fridge temperatures, food temperatures and cleaning schedules were monitored daily. There was no documented evidence of an audit in relation to food safety, although staff reported that audits were carried out every three months within the main kitchen in the general hospital.

Evidence of Implementation: There was a sufficient number of catering staff to ensure that standards in relation to food safety were achieved. The kitchen area was inspected and was an adequate size, was hygienic and had suitable equipment for the refrigeration, storage and preparation of food. The fridge temperature was high but had been reported and was being addressed at the time of inspection. The kitchen had appropriate hand washing facilities available. Staff wore aprons and hair nets when serving meals. There was an adequate supply of crockery and cutlery provided to residents. Food waste was disposed of appropriately. The most recent Environmental Health Officer’s report (EHO) was made available to the inspection team.

Compliance Rating:

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3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There were processes in place to ensure that suitable clothing was available to residents. If a resident did not have access to an adequate supply of suitable clothing, the approved centre had processes in place to obtain night attire from the general hospital.

Training: Staff were aware of and understood the processes to ensure that residents had adequate supplies of clothing.

Monitoring of Compliance: There was no documented audit in place to monitor resident clothing.

Evidence of Implementation: All residents were dressed in their own clothing. All but one resident had a wardrobe to store their clothes. Residents appeared to have an adequate supply of clothing. Each resident had a personal bedside storage unit. The approved centre had no supply of emergency clothing or night attire. Staff obtained clothing from the general hospital when necessary.

Compliance Rating:

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3.8 Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy available relating to residents’ personal property and possessions in the approved centre. It was signed and in date. The policy outlined the procedure for the recording and safe-keeping of residents’ personal property.

Training: Staff were familiar with the procedures and processes involved in accounting for residents’ property including monies received. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit of processes relating to residents’ personal possessions.

Evidence of Implementation: Residents’ monies and valuables were stored in a locked box in the property store room. The key for this was held by the nurse in charge. The approved centre was accountable for residents’ monies, which were safeguarded by staff. Two nurses and the resident signed deposits and withdrawals for residents’ monies. The approved centre maintained a property checklist for each resident. A copy was retained in the clinical file. Residents did not have access to their own lockable storage facilities.

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3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a regular schedule of recreational activities provided within the approved centre. The occupational therapist and multi-task attendant were responsible for the provision of recreational activities.

Training: Relevant staff were aware of the processes in relation to the provision of recreational activities.

Monitoring of Compliance: There was no documented audit on recreational facilities.

Evidence of Implementation: A timetable of recreational activities provided in the approved centre was visible. Appropriate resources, as well as indoor and outdoor space, were available to facilitate the provision of recreational activities. Risk assessments were completed by the multidisciplinary team to ensure safe engagement in recreational activities.

Residents had access to a small gym with exercise equipment and there were books, DVDs and newspapers available in the approved centre. Gardening activities and arts and crafts groups were facilitated. Residents had the use of an indoor football table and a keyboard.

Residents’ likes and dislikes were considered and accommodated in relation to recreation. A checklist was completed by the OT on admission with each resident to elicit their recreational preferences. Records of participation and engagement were documented.

Compliance Rating:

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3.10 Regulation 10: Religion

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

Inspection Findings

Processes: There were processes to facilitate residents in the practice of religion. The approved centre had a documented process to identify the residents’ religious beliefs and wishes. Religious beliefs were considered at admission and facilitated as required.

Training: Staff were aware of the processes in relation to facilitating religious practices. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit on the management of religious observation. Staff informally monitored the processes depending on the resident profile based on assessed needs.

Evidence of Implementation: Residents had access to multi-faith ministers and religious requirements were catered for on an individual needs basis. Residents were facilitated to access local religious services. Any wish of residents to abstain from religious practice was respected. A catholic minister visited the approved centre regularly. The information booklet outlined how to access religious services.

Compliance Rating:

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Ref MHC – FRM – 001- Rev 1
3.11 Regulation 11: Visits

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy on visits which was signed and in date. The policy outlined the roles and responsibilities relating to visits and the process for restricting visitors. It outlined the arrangements for children visiting and the appropriate facility provisions.

Training: Staff were aware of the processes in place for facilitating visitors in the approved centre. There was documented evidence that nursing staff had read and understood the policy.

Monitoring of Compliance: There was no formal documented audit on visits. Visits were monitored on an individual basis depending on residents' wishes and their assessed risk.

Evidence of Implementation: Visiting arrangements were clearly communicated to the resident on admission. Information was displayed at the entrance of the approved centre and in the information booklet. Visiting times were flexible outside of therapeutic groups and meal times.

If a resident did not wish to have a particular visitor this was respected, documented in the clinical file and verbally communicated amongst staff. If a visitor was restricted from visiting the unit, the reasons why were clearly communicated to the visitor and the resident.

Children visiting the approved centre were accompanied by an adult and a separate family room was available. This room was recently decorated with painted murals and was very welcoming for children. There were toys and toilet facilities provided.

Compliance Rating:

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3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: There was a written policy in place which was signed and in date. It identified communication services available to residents. Privacy entitlements were considered. There was no reference to interpreter services in the approved centre within the policy, although provisions were available to facilitate this. It was policy that residents were not allowed to keep their mobile phones in the approved centre.

Training: Staff were aware of the processes in place for the provision of communication services within the approved centre. There was documented evidence that nursing staff had read and understood the policy.

Monitoring of Compliance: There was no formal documented audit on communication processes.

Evidence of Implementation: Communication needs were assessed at admission. An interpreter service was available on request. Residents had access to a telephone and a computer. Residents were not permitted to use their own personal mobile phones. Incoming or outgoing mail was not opened by staff unless a risk was identified; in this case, the nurse in charge monitored such mail.

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3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy on searches in the approved centre. It was signed and in date. The policy identified the context in which searches could be carried out. The policy addressed the requirement to obtain a resident’s consent for a search and the procedure to be followed in the event that consent was not provided. The policy specified that a record of searches must be documented and a separate policy was available for the discovery of illicit substances.

Training: Staff demonstrated an awareness of the processes involved in carrying out a search. There was documented evidence that nursing staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit on the process of searches.

Evidence of Implementation: Searches were undertaken on the basis of individual risk assessment. The clinical file of one resident who had a search carried out was inspected. The procedure was communicated to the resident prior to the commencement of the search. Consent was sought but the resident refused. The search was authorised by the nurse in charge as it was clinically indicated based on risks identified. The resident was informed of the reasons for the search being undertaken. The search was carried out by two staff, at least one of whom was the same gender as the resident being searched. A written record was maintained.
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- Non-Compliant – Poor Achievement (2)
- Compliant – Good Achievement (3)
- Compliant – Excellent Achievement (4)
- Not-Applicable
3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a policy available which was signed and in date. The policy addressed the procedures in relation to expected and sudden deaths. The appropriate notification of a death to the Mental Health Commission (MHC) was outlined in the policy. It also referenced the importance of providing dignity, privacy and religious practices as required.

Training: Staff were familiar with the policy and their role in providing appropriate care for the dying. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit of the processes relating to end of life care.

Evidence of Implementation: There were no deaths in the approved centre since the previous MHC inspection. Staff interviewed reported that end of life care could be provided. Visiting arrangements, a single room and religious and spiritual preferences could be accommodated in the approved centre. Should pain management be required, appropriate arrangements could be put in place via referral to external specialists. The death of one resident of the approved centre had occurred in 2015. This death occurred in the general hospital and was reported to the MHC within 48 hours.
### 3.15 Regulation 15: Individual Care Plan

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

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

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**Inspection Findings**

**Processes:** There were processes in place in relation to the development and management of individual care plans (ICPs).

**Training:** Staff were aware of the processes and requirements in relation to ICPs. There was no formal training on care planning processes.

**Monitoring of Compliance:** There was a documented audit on the process of care planning completed in April 2015.

**Evidence of Implementation:** The clinical files of 15 residents were inspected and all residents had an ICP. An initial care plan was developed at admission following a comprehensive assessment including a mental state examination, assessment of medical, psychosocial and psychiatric history. Following admission, an ICP was developed with the multidisciplinary team (MDT). There was evidence of resident involvement in the care planning process for each clinical file inspected.

Key working was evident in all files. Risk was assessed at admission and risk management was considered on an ongoing basis. ICPs were reviewed weekly; residents were invited to attend and their care plan was discussed and made available to them at these meetings.

Each ICP inspected had identified needs, goals and appropriate resources. There was evidence of discharge planning and the ICPs reflected the residents’ current needs.

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3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: There were processes for the provision of therapeutic services within the approved centre. The availability of therapeutic activities was communicated to residents in the information booklet.

Training: Relevant staff were aware of the processes in relation to the provision of therapeutic services. The occupational therapist was trained professionally to deliver therapeutic services and programmes.

Monitoring of Compliance: There was no documented audit on therapeutic service provision.

Evidence of Implementation: A schedule of therapeutic activities was displayed and a copy was given to each resident. Groups included: life skills, recovery principles and relaxation. There was adequate space to facilitate therapeutic services. Residents had access to a new occupational therapy kitchen and gym since the previous inspection. Records of attendance at therapeutic activities were maintained and documented engagement for each resident.

An occupational therapist and a multi-task attendant were involved in the provision of therapeutic activities. The multidisciplinary team (MDT) had an allocated social worker and a psychologist was accessible by referral. Resident engagement was reviewed at the MDT meetings and this was reflected in the residents’ individual care plans.

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3.17 Regulation 17: Children’s Education

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

Inspection Findings

The service had a policy relating to the procedures for accessing education for children who were admitted to the approved centre. Five children had been admitted to the approved centre in 2015 prior to inspection. As there were no children in the approved centre at the time of inspection, this regulation was not applicable.

Compliance Rating:

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3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: There was a written policy on the transfer of residents which was signed and in date. The roles and responsibilities were identified in the planning and management of resident transfers.

Training: Staff were aware of the procedures and requirements in relation to transferring a resident to another facility. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit on the process of transferring residents.

Evidence of Implementation: The clinical file of one resident who had been transferred to another facility was inspected. The resident was assessed and met the transfer criteria. A decision was made to transfer and this was communicated with the resident and their family. Consent was obtained from the resident prior to the transfer. MDT and keyworker involvement was documented as was communication with the receiving facility. A copy of all relevant information was sent with the resident and their property was transferred with them. This was documented and managed appropriately. This transfer was planned and took place during the day. The ICP was updated to reflect the transfer.

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3.19 Regulation 19: General Health
(1) The registered proprietor shall ensure that:
(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
(c) each resident has access to national screening programmes where available and applicable to the resident.
(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

Inspection Findings

Processes: The approved centre had a policy for the management of medical emergencies. This policy was signed and in date. Roles and responsibilities were outlined as were the procedures for responding to a medical emergency. The approved centre had defined processes in place to complete Basic Life Support (BLS) every two years.

There were defined processes in place to ensure that residents had access to a registered medical practitioner and that general healthcare needs were considered. Provisions were in place for access to general healthcare services and for residents to access screening programmes.

Training: Records indicated that only four nurses had received BLS training within the previous two years. Staff were aware of the processes for providing general health services.
There was documented evidence that nursing staff had read and understood the policy for the management of medical emergencies.

Monitoring of Compliance: There was no audit on the process of general health processes. There was no documented record of the uptake of resident screening.

Evidence of Implementation: Residents had access to a registered medical practitioner. A full systematic physical review was completed on admission and health needs were identified. Appropriate facilities were available to ensure the privacy and dignity of residents. General health needs were identified and recorded in the individual care plans. Referrals to external physical healthcare providers were facilitated as required. Healthy lifestyle choices and recreation were facilitated. Residents had access to the exercise equipment. Information on screening programmes was made available to the residents, as required.

There was an emergency response trolley which was checked daily. Emergency responses were recorded in the risk register.

Four residents were in the approved centre for longer than six months. Each clinical file was inspected and there was evidence that six-monthly physical assessments were completed.
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- Compliant – Good Achievement (3)
- Compliant – Excellent Achievement (4)
- Not Applicable
3.20 Regulation 20: Provision of Information to Residents

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

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

Inspection Findings

Processes: There was a written policy available relating to the provision of information in the approved centre. It was signed and in date. There were processes to ensure the provision of information to residents on diagnosis, medication interpretation and advocacy services.

Training: There was no documented evidence of specific training in relation to the provision of information. Staff interviewed were familiar with the policy on the provision of information. There was documented evidence that nursing staff had read and understood the policy.

Monitoring of Compliance: There was no documented evidence of audit on the provision of information to residents.

Evidence of Implementation: An information booklet was available to residents with a range of information, including: admission procedure, visiting times, complaints procedure, patients’ rights and individual care planning.

Communication needs were assessed on admission and incorporated into the residents’ individual care plans, if required, to enable the suitable provision of information. Residents had access to an interpreter. Written information on diagnosis and medication was available for residents. Information on advocacy services was available on noticeboards. Health and safety procedures were publicly displayed in the approved centre.

Compliance Rating:

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3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There were defined processes in place to afford privacy to residents. Private facilities were available for meeting with residents or their families.

Training: Staff were aware of the processes in relation to resident privacy. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit on privacy.

Evidence of Implementation: Throughout the inspection, staff were observed to respect residents’ privacy and dignity and knocked before entering residents’ bedrooms. All toilets were fitted with a lock inside to ensure privacy. These locks could be opened by staff if necessary. The use of CCTV was for security purposes only and didn’t impact negatively on residents’ dignity or privacy.

The courtyard was overlooked by the general hospital. This was discussed at the feedback meeting and a service user representative from the Business Management team assured the inspection team that residents had been consulted in relation to this issue. Feedback from over 90% of residents was that screening the windows overlooking the courtyard would only compound stigma surrounding mental illness and segregate residents further.

It was noted that observation panels on three single bedroom doors permitted observation from common areas. Privacy was compromised for residents in these rooms. Panels were partly screened but did not incorporate any form of curtain or blind within the room to afford privacy. The affront to resident privacy and dignity, associated with lack of adequate screening in these rooms, deemed the approved centre non-compliant with this regulation.

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### 3.21 Regulation 21: Privacy

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

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<tbody>
<tr>
<td>CAPAs</td>
<td>Specific</td>
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<tr>
<td><strong>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</strong></td>
<td>Define the area of non-compliance addressed by this CAPA</td>
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<tr>
<td>1. Observation windows in 3 bedroom doors fully covered with privacy film: corrective action</td>
<td>Insufficient patient privacy</td>
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Post-Holder(s): Deirdre McPhillips, ADON
3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:
(a) premises are clean and maintained in good structural and decorative condition;
(b) premises are adequately lit, heated and ventilated;
(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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


Inspection Findings

Processes: There were defined processes in place for managing premises. There were defined processes in relation to daily maintenance and cleaning of the approved centre and infection control measures were in place.

Training: Relevant staff were aware of the processes and procedures in relation to premises.

Monitoring of Compliance: There were no documented audits on hygiene or infection control. Maintenance issues were reviewed under health and safety at the monthly Quality and Patient Safety Group meetings. A ligature audit had been completed and ligature point minimisation was evident.

Evidence of Implementation: The approved centre was not designed specifically for the provision of care for persons with a mental illness. The building was of sound structure. The approved centre was warm, well ventilated, with hot water and adequate lighting. Residents had adequate personal and outdoor space. There were adequately sized communal rooms and dedicated therapy spaces. The addition of the occupational therapy kitchen and gym facilities were a significant improvement since last year’s inspection. There were adequate wheelchair accessible toilet facilities.

There was a daily cleaning schedule provided by contract cleaners. Ongoing maintenance was managed via the general hospital. The approved centre had been painted throughout and the floor covering had been replaced since the previous inspection in 2014. An artist had painted murals throughout the approved centre with many recovery-orientated messages which created a positive atmosphere. Although the soft furnishings throughout were dated, the assistant director of nursing confirmed that new furnishings had been
secured and were due to arrive in January 2016.

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

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


Inspection Findings

Processes: There was a written policy available covering the management of prescribed medications in the approved centre. It was signed and in date. The processes for ordering, prescribing, storing and administration of medication were clearly defined within the policy.

Training: Relevant staff were trained in the processes and procedures required in the management of medication through their professional training. There was documented evidence that nursing staff had read and understood the policy on medication management. Eleven nurses had completed Medication Management training on HSE land: an online learning portal.

Monitoring of Compliance: There was no documented audit on the process of medication management.

Evidence of Implementation: The nursing staff were responsible for the ordering of medications. Stock was reviewed and expiry dates monitored by a pharmacist.

Prescriptions were completed by registered medical practitioners (RMP). A new Medication Prescription and Administration Record (MPAR) was in place since the previous MHC inspection in 2014 and it was observed to be of a high standard.

An MPAR was maintained for every resident. Sixteen MPARs were inspected and the findings were as follows:

- Each resident was identifiable with a name, date of birth and unique Medical Record Number
- Medications were generically prescribed and abbreviations were not used
- All prescriptions recorded the Medical Council Registration Number (MCRN)
- All prescriptions were signed by the RMP
- All prescriptions were prescribed with dose, frequency, route and clear start and stop dates
- Four MPARs did not have the allergy section completed
- Administration of medication was recorded in all instances with a reason documented if medication was omitted

Medications were stored in a locked medicine trolley which was secured to the wall or a locked cupboard within a locked clinical room. The medicine cupboard was crowded. Medication that required refrigeration was stored in a temperature-controlled fridge. However, the temperature log had not been maintained since December 2014. The clinical room was cleaned weekly by nursing staff. Medications were disposed of...
appropriately.

Staff had access to up-to-date information on medication management. Medications were administered by a registered nurse to residents who were identified by their name and date of birth. Controlled drugs were managed in accordance with relevant legislation. Two registered nurses checked and signed all controlled drugs that were administered.

Although a pharmacist monitored stock occasionally, there was no pharmacist involvement in the multidisciplinary team. The acting executive clinical director confirmed at the feedback meeting that negotiations were in place to secure regular pharmacist input.

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3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: The approved centre had written operational policies in relation to health and safety issues. It addressed safety issues in relation to staff, residents and visitors. Roles and responsibilities were clearly defined within the safety statement.

Training: There was documented evidence that seven nurses had completed up-to-date fire safety training. Ten nurses had completed manual handling training. Hand hygiene training had been completed for twelve nurses.

Monitoring of Compliance: A ligature audit was completed in the approved centre and ongoing improvement opportunities identified as a result. Health and safety issues were monitored monthly at Area Mental Health Management meetings and Quality and Patient Safety Group meetings.

Evidence of Implementation: There was a safety statement available to the inspection team. The approved centre maintained a Risk Register which assessed and documented issues of concern. Health and safety incidents were recorded.

Hand washing facilities and alcohol gel dispensers were observed throughout the approved centre. Healthcare waste was managed appropriately and sharps boxes were available and disposed of safely.

Personal Protective Equipment was available for carrying out clinical tasks. An infection control nurse was available in the general hospital to provide information and advice in relation to infection control measures. A falls prevention initiative was in place.

There was no documented record of staff vaccinations. Staff had access to changing, shower and toilet facilities.

Fire precautions were in place and the approved centre had emergency lighting and a fire management plan in place. The Fire Officer’s report was available and had been carried out in April 2011. There was a hospital-wide upgrade of the fire detection and alarm system, emergency lighting and fire compartmentation underway at the time of inspection.

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

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

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

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

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

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

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

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

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

Inspection Findings

The approved centre had a policy on the use of CCTV. It was signed and in date. CCTV was not used for clinical observation purposes. Therefore, this regulation was not applicable.

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3.26 Regulation 26: Staffing

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

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

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

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

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

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

Inspection Findings

Processes: Recruitment of staff was based on HSE recruitment policies. It addressed issues in relation to recruitment, selection and vetting processes. There were defined processes in place in relation to training for all staff. Timeframes for mandatory training were outlined clearly within this. The Mental Health Act 2001 and associated rules and regulations were available to all staff.

Training: Staff interviewed were aware of the processes in relation to staffing. There was no formal documented evidence to support that mandatory training was in date for all staff.

Monitoring of Compliance: No formal audits or analysis were available in relation to staffing. Nurse staffing levels were dynamic, were monitored and adjusted according to the needs of residents. Training gaps were identified by senior management based on identified needs of residents. Training was provided to address these needs. Staffing needs were monitored and addressed at monthly Area Mental Health Management Team meetings.

Evidence of Implementation: There was an organisational chart available on inspection identifying the leadership and management structure of the approved centre. There was no documented evidence of staffing plans, training needs or necessary skill mix available. An up-to-date staff roster was inspected and there were sufficient staffing levels and skill mix to meet the residents’ needs. There was an identified person in charge on each shift. Staffing levels were dynamic and changed to reflect residents’ needs. Staff informed the inspection team that staffing on the unit was as follows:

Nursing staff for the approved centre:

- Assistant Director of Nursing (ADON) – One
- Clinical Nurse Manager 2 – Four
- Registered Psychiatric Nurse (RPN) – 23.5 x WTE
- Multi-Task Attendant – One

The approved centre was staffed daily with a CNM 2 and four RPNs and at night with a
CNM 2 and three RPNs. The CNM 2 at night acted up to CNM 3 grade due to extra responsibilities in liaison with the emergency department. Agency staff were contracted to the unit occasionally.

There were two consultant psychiatrist-led teams. Each team had access to a registered medical practitioner, a clinical psychologist, a social worker and an occupational therapist.

Residents also had access to other clinicians by referral such as: speech and language therapist; infection control nurse; dietician; and other medical specialists.

Two staff personnel files were reviewed. One file included evidence of Garda vetting, qualifications, two references, job description, contract of employment, copy of curriculum vitae and identification of the staff member. The second file did not contain a copy of the job description or identification of the staff member.

The approved centre provided formal induction and orientation training for new staff members. Staff evaluations were completed by the CNM 2. Staff did not complete performance appraisals. There was a pilot project to introduce clinical supervision for nursing staff in the Cavan/Monaghan Mental Health Service, with potential to roll it out in the approved centre if it was successful.

Staff training records were reviewed. There was documented evidence available on inspection to reflect that not all staff were up to date in training in Professional Management of Aggression and Violence, Basic Life Support, manual handling and fire safety training.

The approved centre did not ensure that up-to-date training was provided to all relevant staff on a timely basis to enable staff to provide care and treatment in accordance with best practice. This is a requirement of the regulation and, therefore, the approved centre was deemed non-compliant with this regulation.

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

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<tr>
<td>19th February 2016</td>
<td>Define the action <strong>and</strong> state if it is corrective or preventative <strong>and</strong> state post-holder(s) responsible</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
<td>State method of evaluation and monitoring of outcome</td>
<td>State feasibility of action</td>
<td>State time-frame for completion of action</td>
</tr>
<tr>
<td>1. Ensuring staff access to education and training in accordance with best contemporary practice: Corrective and preventive action</td>
<td>Training records for all Approved Centre staff</td>
<td>Assignment of CNM 2 with specific responsibility for routine, ongoing monitoring/auditing and reporting to senior management of staff mandatory education and training</td>
<td>High</td>
<td>CNM 2 assigned 1/2/16 and ongoing</td>
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Post-Holder: ADON /ECD
3.27 Regulation 27: Maintenance of Records

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

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

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


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

Inspection Findings

Processes: There was a policy on the keeping of records. It was signed and in date. The policy provided guidance on the access to, storage, retention and destruction of records. It outlined the roles and responsibilities in relation to the management of records and residents’ rights to access their own records.

Training: Staff were aware of the requirements in relation to the maintenance of records. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: An audit was completed on the maintenance of records.

Evidence of Implementation: Each resident had a clinical file with a unique identifier which was up to date. Each clinical file contained information on the residents’ diagnoses and treatment plan. Information was difficult to retrieve at times as the information was not always stored in chronological order. There were loose pages in some clinical files. Current residents’ files were stored securely in a filing cabinet in a locked office.

Copies of the fire inspection report, the EHO report and the site-specific safety statement were retained on site.

Clinical files of discharged residents containing personal information were stored in a room in the corridor outside the approved centre. This room was unlocked on the first day of inspection and was accessible to members of the public. The area director of nursing addressed this issue promptly and a lock was placed on the door. On the final day of inspection, the room was found to be unlocked again.

The regulation states that records shall be kept in a safe and secure place. Clinical files were not stored securely and, therefore, the approved centre was deemed non-compliant with this regulation.
### Compliance Rating:

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### 3.27 Regulation 27: Maintenance of Records

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

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<td>State feasibility of action</td>
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<td>State time-frame for completion of action</td>
</tr>
<tr>
<td>1. To ensure patient records are kept in a safe and secure place all files moved to a secure physical location</td>
<td>File store room found unlocked which allowed access to clinical files</td>
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<td></td>
<td>Review of file storage system completed</td>
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<td></td>
<td>High</td>
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<td>Post-Holder(s): Margaret Caulfield</td>
<td>Completed</td>
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3.28 Regulation 28: Register of Residents

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

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

Inspection Findings

The approved centre held an electronic register of residents which was up to date and incorporated the information required by Schedule 1.

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3.29 Regulation 29: Operating Policies and Procedures

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

Inspection Findings

Processes: The approved centre had operational policies and procedures. There were defined processes in place which indicated the review frequency and the procedure for approval of policies.

Training: Relevant staff were aware of the process for review of policies.

Monitoring of Compliance: Policies were reviewed and approved by senior clinical and management staff. The policy on physical restraint was reviewed annually. All policies required by legislation were monitored and reviewed appropriately.

Evidence of Implementation: The policies were developed with the involvement of senior medical, nursing, social work, occupational therapy and administrative staff as well as service users. They incorporated relevant legislative requirements and were approved by the acting executive clinical director. Policies were communicated to staff and this was documented. Hard copies were held within the approved centre and were available to staff.

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3.30  Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

Processes: There were processes in place for facilitating mental health tribunals.

Training: The training records showed that staff had received training in the Mental Health Act 2001. Relevant staff were aware of the requirements in relation to facilitating Tribunals.

Monitoring of Compliance: Procedures and outcomes of Tribunals were monitored by the MHA administrator.

Evidence of Implementation: Tribunals were held in a private facility within the approved centre and resources were provided to facilitate Tribunal hearings. Nursing staff were made available to attend Tribunals if required. Staff provided residents with relevant written or verbal information in a manner they could understand.

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3.31 Regulation 31: Complaints Procedure

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a written policy addressing the making, management and handling of complaints. It was signed and in date. The policy outlined responsibilities and processes for responding to complaints.

Training: Relevant staff were aware of the requirements of the complaints procedure and their role in implementing same. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: Complaints logs were maintained. Complaints were monitored by the local complaints officer and addressed promptly. Complaints were a regular item on the agenda at monthly Patient Safety and Quality Group Meetings.

Evidence of Implementation: The roles and responsibilities of staff were clearly defined. The complaints process was outlined in the information booklet and displayed in prominent positions throughout the approved centre. A nominated complaints officer was identified and communicated to residents. A comments box was available and information on advocacy services were publicly displayed. There was a consistent approach for the management of complaints at management level and records indicated prompt investigation. Complaints were recorded and maintained separate to the residents’ clinical files.
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3.32 Regulation 32: Risk Management Procedure

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

Inspection Findings

Processes: There was a policy in place in relation to risk management. It was signed and in date. There were defined processes in place to address risk relating to residents being absent without leave, aggression and deliberate self-harm. There was a process to assess risk on admission and regularly thereafter. The policy on risk management did not make reference to the procedures in relation to accidental injury to residents or staff or arrangements for the protection of children or vulnerable adults. It did not address arrangements for responding to emergencies.

Training: Staff were aware of the process for recording and reporting risk incidents. Clinical staff were trained in risk assessment. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit on risk management procedures. Risk was reviewed monthly at Quality and Patient Safety Group and Area Mental Health Management Team meetings.

Evidence of Implementation: Responsibilities for risk management were allocated at management level within the approved centre. There were clear governance structures in place. Health and safety risks were documented in the Risk Register. Incidents were recorded on incident report forms which were forwarded to senior management for reviewing risk. The approved centre sent a summary of incidents to the MHC every six months. An emergency plan was in place.

Individual and clinical risk assessment formed part of the ICP. Fifteen clinical files were inspected. All residents had an admission risk assessment completed. Risk was considered at the weekly ICP review meetings in all clinical files.
Although there were processes in place to manage risk effectively, the policy on risk management did not make reference to the procedures in relation to accidental injury to residents or staff or arrangements for the protection of children or vulnerable adults. It did not address arrangements for responding to emergencies. This is a requirement set out in Regulation 32, therefore, the approved centre was deemed non-compliant with this regulation.

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3.32 Regulation 32: Risk Management Procedure

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<tr>
<td>1. Ensuring risk management policy references policies on (a) accidental injuries to residents and staff, (b) arrangements for protection of children and vulnerable adults and (c) responding to emergencies. Preventative action</td>
<td>Comprehensive, written risk management policies</td>
<td>Review of existing policies and updating to include all outstanding requirements as outlined in Regulation 32.</td>
<td>High</td>
<td>Completed by 30/04/2016</td>
<td></td>
</tr>
</tbody>
</table>

Post-Holder(s): Lynda Bradley, CNM 2- Quality & Clinical Audit & ECD
3.33 Regulation 33: Insurance

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

**Inspection Findings**

The approved centre had insurance cover as provided to the HSE by the State Claims Agency.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
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</table>
3.34  Regulation 34: Certificate of Registration

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

### Inspection Findings

The Certificate of Registration, with conditions attached, was displayed in a prominent area within the approved centre.

### Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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Ref MHC – FRM – 001- Rev 1  
Page 53 of 69
### 4.0 Inspection Findings and Required Actions - Rules

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

#### 4.1 Section 59: The Use of Electro-Convulsive Therapy

**Section 59**

(1) “A programme of electro-convulsive therapy shall not be administered to a patient unless either –

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or

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

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.”

#### Inspection Findings

A condition was attached to the approved centre regarding the use of ECT following the 2014 inspection findings. ECT had not been prescribed in the approved centre since the condition was attached and no patient was receiving ECT elsewhere. Therefore, this rule was not applicable.

#### Compliance Rating:

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

Inspection Findings
As seclusion was not used in the approved centre, this rule was not applicable.

Compliance Rating:

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
<th>Compliant – Excellent Achievement (4)</th>
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</table>
4.3 **Section 69: The Use of Mechanical Restraint**

_Mental Health Act 2001_

**Bodily restraint and seclusion**

Section 69

(1) “A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section “patient” includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient”.

**Inspection Findings**

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

**Compliance Rating:**

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<tr>
<th>Achievement (1)</th>
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<td><strong>Non – Compliant</strong>&lt;br&gt;Poor Achievement</td>
<td><strong>Compliant</strong>&lt;br&gt;Good Achievement</td>
<td><strong>Compliant</strong>&lt;br&gt;Excellent Achievement</td>
<td><strong>Not Applicable</strong></td>
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</table>
5.1 Part 4: Consent to Treatment

56. In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –
   (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   (b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either –
   (a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   (b) where the patient is unable or unwilling to give such consent –
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

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

61. Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –
   (a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   (b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

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

Inspection Findings

Processes: There was a defined process for obtaining consent to treatment. Consent requirements in relation to patients were documented on a form which reflected that the patient gave consent to the continued administration of medication.

Training: Relevant staff were aware of the requirements in relation to appropriate consent and their role in ensuring compliance.

Monitoring of Compliance: There was no documented audit on consent. The MHA
administrator monitored the process within the required timeframes.

*Evidence of Implementation:* One patient had been in the approved centre and administered medication for longer than three months without consent. There was a statutory form in the patient’s clinical file which authorised the continued administration of medication.

Three patients had been in the approved centre and administered medication for longer than three months with their consent. In each clinical file, there was a form which was signed by both the treating consultant psychiatrist and the patient indicating their approval and authorisation to treatment. It did not make any reference to the purpose, nature and likely effect of treatment, nor did it list the specific medications that the patient was taking.

In one clinical file that was reviewed, there was no documentation to indicate that the patient was given adequate information on the nature, purpose or likely effects of the proposed treatment. This is a requirement in line with Part 4 of the MHA 2001. Therefore, the approved centre was deemed non-compliant with Part 4 of the MHA 2001.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
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## Part 4 Consent to Treatment

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

<table>
<thead>
<tr>
<th>Date received</th>
<th>19th February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPAs</td>
<td>Specific</td>
</tr>
<tr>
<td>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
</tr>
<tr>
<td>1. Ensure that all care plans include documented evidence of provision of information on the nature, purpose and likely effects of proposed treatment in accordance with Part 4 of MHA 2001.</td>
<td>Part 4 MHA 2001</td>
</tr>
<tr>
<td>Post-Holder(s): CNM 2- Quality &amp; Clinical Audit &amp;ECD</td>
<td></td>
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</tbody>
</table>
6.0 Inspection Findings and Required Actions – Codes of Practice

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EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)
Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services.”

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

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

---

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

Inspection Findings

Processes: The approved centre had a policy covering the use of physical restraint which was reviewed annually. It was signed and in date. The policy indicated roles and responsibilities in relation to the initiation and monitoring of physical restraint. The policy required staff to complete training every two years in the prevention and management of violence. Defined processes were in place to ensure the provision of information to residents in relation to physical restraint and child protection measures were addressed.

Training: Relevant staff were aware of the policy and requirements for documentation and recording of incidents of use. There was documented evidence that staff had read and understood the policy on the use of physical restraint. Staff training records reviewed indicated that Professional Management of Aggression and Violence (PMAV) training was out of date, with the exception of three staff members.

Monitoring of Compliance: There was an audit on the process of physical restraint carried out between March and July 2015. The policy was reviewed annually.

Evidence of Implementation: Four clinical files were inspected of residents who had been physically restrained. Thirteen episodes of physical restraint in total were reviewed. Restraint was initiated as a last resort when all other methods of de-escalation had failed and the resident posed an imminent risk to themselves or others. Use was based on a risk assessment. Episodes of restraint were initiated by authorised personnel. The consultant psychiatrist was notified in each case and a medical examination was carried out. The residents and the residents’ next of kin were informed of the restraint and the reasons it was used except in one episode reviewed. The episode of restraint was recorded in the clinical file. Residents’ dignity and safety were considered and respected throughout each episode of physical restraint. Each episode of physical restraint was reviewed by the MDT after the...
event.

The Clinical Practice forms indicated that the use was proportionate and for a minimum period with minimum force. Three clinical practice books relating to 2015 episodes of physical restraint were inspected. The findings were as follows:

- Two clinical practice forms were incomplete.
- In 47 clinical practice forms the section to inform next of kin was blank.
- There were 14 instances where the next of kin was not informed.
- There were seven episodes where a female was physically restrained but only male staff were documented to have attended the restraint.
- There was one episode where only female staff were in attendance during the restraint of a male resident.
- A security guard was involved in two physical restraint episodes.

Management confirmed that security personnel were not usually involved in episodes of physical restraint and only became involved as a last resort. They received breakaway training. There was documentary evidence security staff had received training in March 2013. Interviews with clinical staff and observation of the clinical notes confirmed that during episodes of physical restraint involving a male or female resident, there was always a same sex member of staff present.

The code of practice (COP) on the use of physical restraint outlines that training in the prevention and management of violence is completed. Training was out of date. Because of this and the reasons outlined above the approved centre was deemed non-compliant with this COP.

<table>
<thead>
<tr>
<th>Compliance Rating:</th>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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X
### 6.1 The Use of Physical Restraint

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

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<tr>
<td>Define the action <strong>and</strong> state if it is corrective or preventative <strong>and</strong> state post-holder(s) responsible</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
</tr>
<tr>
<td>Define the action <strong>and</strong> state if it is corrective or preventative <strong>and</strong> state post-holder(s) responsible</td>
<td>Define the area of non-compliance addressed by this CAPA</td>
</tr>
<tr>
<td>1. Ensuring full completion of Clinical Practice Forms in relation to use of physical restraint, to include informing next of kin: preventive action</td>
<td>Code of Practice with regard to Physical Restraint</td>
</tr>
<tr>
<td>Post-Holder(s): CNM 2, Approved Centre</td>
<td></td>
</tr>
<tr>
<td>2. Ensuring that every Clinical Practice Form records presence of all staff attending to reflect presence of a same sex staff member</td>
<td>Code of Practice with regard to Physical Restraint</td>
</tr>
<tr>
<td>Post-Holder(s): CNM 2, Approved Centre</td>
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</tbody>
</table>
6.2 Admission of Children

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

Inspection Findings

Processes: There was a policy on the admission of children which identified the procedures for admitting a child to this adult unit. The policy was signed and in date.

Training: There was documented evidence that five nursing staff had received training in the Children First national guidelines on protection of children. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: Monitoring on compliance with the processes had not been carried out.

Evidence of Implementation: Five children had been admitted to the approved centre in 2015 to the time of the inspection. The clinical files of two of these children were inspected.

Both admissions were voluntary admissions and there was evidence in the clinical files that consent for admission and treatment had been obtained from the parent or guardian. A nurse was assigned to provide one-to-one observation of the child for the duration of the admission.

While in the approved centre, the children were under the care of the adult psychiatry teams and there was evidence of regular contact with the Child and Adolescent Mental Health Services (CAMHS) in an attempt to secure an appropriate bed.

As the approved centre was a unit for the admission of adults, it was not suitable for the admission of children. The approved centre was, therefore, not compliant with this code of practice.

Compliance Rating:

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<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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Risk Rating:

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</table>
### 6.2 Admission of Children

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

<table>
<thead>
<tr>
<th>Date received</th>
<th>19th February 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPAs</td>
<td>Specific</td>
</tr>
<tr>
<td><strong>Define the action and state if it is corrective or preventative and state post-holder(s) responsible</strong></td>
<td>Define the area of non-compliance addressed by this CAPA</td>
</tr>
<tr>
<td>1. Ensuring admission of children to an appropriate setting: preventive action</td>
<td>Adult in-patient unit unsuitable for the admission of children</td>
</tr>
<tr>
<td>Post-Holder: Chief Officer, CHO 1</td>
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</tbody>
</table>
6.3 Notification of Deaths and Incident Reporting

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

**Inspection Findings**

*Processes:* There were defined processes in place to ensure that deaths and incidents were reported to the MHC and roles and responsibilities were clearly defined.

*Training:* Relevant staff were aware of the processes and requirements of incident reporting and notification of deaths to the MHC. Training was documented.

*Monitoring of Compliance:* There was no documented audit review process in place. The processes were monitored by the Mental Health Act administrator and at monthly Area Mental Health Management meetings.

*Evidence of Implementation:* One resident of the approved centre died in the general hospital, since the last inspection. The approved centre submitted a death notification form to the MHC within 48 hours of the occurrence. A summary of incidents was sent to the MHC every six months. A risk management policy was in place. The approved centre maintained an incident record and a summary of this was made available to the MHC.

**Compliance Rating:**

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<tr>
<th>Non-Compliant – Negligible Achievement (1)</th>
<th>Non-Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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6.4 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

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

Inspection Findings

Processes: There was a policy in place. It was signed and in date. The policy addressed issues to be considered in providing care for persons with mental health issues and an intellectual disability. The policy prioritised a person-centred approach in a least restrictive environment. Processes were in place in relation to managing problem behaviour and communication with external agencies.

Training: There was documented evidence that staff had received intellectual disabilities training. There was documented evidence that staff had read and understood the policy.

Monitoring of Compliance: There was no documented audit available.

Evidence of Implementation: There was one resident in the approved centre with a mental illness and an intellectual disability. This resident’s communication needs were considered at the initial assessment and thereafter. Staff of the approved centre were mindful of the resident’s preferences for short conversations. Restrictive practices were avoided and inter-agency collaboration was prioritised. The resident had an individual care plan which was appropriate to the specific needs of the resident. The resident was nursed in a single room.

Compliance Rating:

<table>
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<th>Compliant – Good Achievement (3)</th>
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6.5 The Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

**Inspection Findings**

There was a condition attached to the registration of the approved centre regarding the
use of ECT in the approved centre. ECT had not been undertaken in the approved centre
since the condition was attached and no patient was receiving ECT elsewhere. Therefore,
this code of practice was not applicable.

**Compliance Rating:**

<table>
<thead>
<tr>
<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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6.6 Admissions, Transfer and Discharge

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

Inspection Findings

Processes: There were policies on admission, transfer and discharge of residents. All were signed and in date.

Training: Staff were aware of the processes in relation to admission, transfer and discharge processes. There was documented evidence that staff had read and understood the policies.

Monitoring of Compliance: There was no documented evidence of audits on the processes of admission, transfer or discharge. The processes of admission and discharge were monitored by the use of a checklist to ensure that all the necessary steps had been taken.

Evidence of Implementation:

Admission: Four clinical files were inspected. Two admissions were planned and two were unplanned. In each case, the resident was suffering with a mental illness and it was in their best interests to be admitted to the approved centre. The decision to admit was made by a registered medical practitioner (RMP). An admission assessment was completed on each resident. Records were available as well as an initial care plan and, following MDT review, an ICP was developed. Each resident was assigned a keyworker on admission. There was evidence of collaboration with community mental health services and family members. The admission process was captured on a checklist which was completed by nursing staff to ensure that the process was adhered to correctly.

Transfer: The clinical file of one resident who had been transferred to another facility was inspected. The resident was assessed and met the transfer criteria. A decision was made to transfer and this was communicated with the resident and their family. Consent was obtained from the resident prior to the transfer. MDT and keyworker involvement was documented, as was communication with the receiving facility. A copy of all relevant information was sent with the resident and their property was transferred with them; this was documented and managed appropriately. This transfer was planned and occurred during the day. The ICP was updated to reflect the transfer.

Discharge: One clinical file was inspected. There was evidence that the decision for discharge was made by the consultant psychiatrist in consultation with the MDT. Discharge planning was documented and the resident and family members were involved in the decision. Two days’ notice was given to the resident. The keyworker was involved in the process. Copies of the discharge summary and prescription were in the clinical file. Property was returned to the resident on discharge. The process of discharge was summarised on a checklist to ensure that all of the appropriate steps had been taken.

Compliance Rating:

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<th>Non – Compliant – Negligible Achievement (1)</th>
<th>Non – Compliant – Poor Achievement (2)</th>
<th>Compliant – Good Achievement (3)</th>
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