Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME:	Central Mental Hospital
IDENTIFICATION NUMBER:	AC0048
APPROVED CENTRE TYPE:	Forensic Psychiatry
REGISTERED PROPRIETOR:	HSE
REGISTERED PROPRIETOR NOMINEE:	Mr Jim Ryan
MOST RECENT REGISTRATION DATE:	1 March 2015
NUMBER OF RESIDENTS REGISTERED FOR:	94
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	5, 6, 7 October 2015
PREVIOUS INSPECTION DATE:	19, 20, 21 August 2014
CONDITIONS ATTACHED:	None
LEAD INSPECTOR:	Dr Susan Finnerty MCN 009711
INSPECTION TEAM:	Dr Fionnuala O'Loughlin MCN 008108 Ms Mary Corrigan Ms Mary Connellan Mr Damien Lanigan Ms Geraldine Corr Ms Lisa Kiernan Ms Lydia Martin
THE ACTING INSPECTOR OF MENTAL HEALTH SERVICES:	Dr Susan Finnerty MCN 009711

Contents

1.0 Mental Health Commission Inspection Process

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

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

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

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

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

Each approved centre shall be assessed against all regulations, rules, 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 an in-patient service of the National Forensic Service. It was located in Dundrum, Dublin and had 94 beds. It was the designated centre under the Criminal Law (Insanity) Act 2006. The main building was over 150 years old and was not suitable for the care and treatment of mental health patients. Plans for the new forensic hospital were progressing.
At the time of inspection, there were 21 patients detained under the Mental Health Act 2001; the remaining patients were detained under the Criminal Law (Insanity) Act 2006.
There were eight units in the approved centre and this allowed the male patients to progress from acute care with high security through medium to low security and rehabilitation. However, all ten female patients were accommodated in one unit, whatever their level of acuity, security requirements and rehabilitation needs. All patients, with the exception of those in Unit 7 and Laurel Lodge, were locked in their bedrooms from 20:45 to 08:00, regardless of individual risk.
Due to the waiting list of seven patients in other approved centres awaiting transfer to the Central Mental Hospital, plans were progressing to renovate and re-open a closed unit (Unit 5) to provide 10 beds for these patients. The completion date for this was the end of 2015.

2.2 Governance

Meetings of the Senior Management Team were held monthly and minutes of recent meetings were made available to the inspection team. These meetings were attended by members of the senior management team together with operational management. The minutes showed that actions were time-lined with a responsible person identified. There was no service user or carer representation in this group, although there was a strong carer's group which had input to decision making. Patients' views were ascertained through a monthly meeting in each unit with the senior management team. The minutes indicated consideration of a variety of issues relating to services in the community, prisons and in the approved centre. The overall impression was of a very active and robust governance structure.

2.3 Inspection scope

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

The inspection was undertaken onsite in the approved centre from:

6 October 2015 at 09:00 to: 8 October 2015 at 18:00

2.4 Outstanding issues from previous inspection

The previous inspection of the approved centre on 19, 20, 21 August 2014 identified the following areas of non-compliance:

Regulation/Rule/Act/Code	Inspection findings 2015
Regulation 6 Food Safety	Non-compliant
Regulation 15 Individual Care Plan	Non-compliant
Regulation 21 Privacy	Non-compliant

Regulation 22 Premises	Non-compliant
Regulation 23 Ordering, Prescribing, Storage and Administration of Medicines	Non-compliant
Regulation 26 Staffing	Compliant

2.5 Conditions to Registration

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

2.6 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 6 Food Safety	Moderate
Regulation 13 Searches	Moderate
Regulation 15 Individual Care Plan	Moderate
Regulation 21 Privacy	Moderate
Regulation 22 Premises	High
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Low
Section 69: The Use of Seclusion	Moderate

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

2.7 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 5 Food and Nutrition
Regulation 9 Recreational Activities
Regulation 11 Visits
Regulation 14 Care of the Dying
Regulation 16 Therapeutic Services and Programmes
Regulation 19 General Health
Regulation 28 Register of Residents
Regulation 31 Complaints
Regulation 32 Risk Management Procedures
Regulation 33 Insurance
Regulation 34 Certificate of Registration

2.8 Reporting on the National Clinical Guidelines

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

2.9 Areas of good practice identified on this inspection

- A consultant psychiatrist with a multidisciplinary team in Mental Illness and Intellectual Disability was due to commence in November 2015.
- With the increased capacity in opening Unit 5, as outlined above, a new consultant-led multidisciplinary team would be appointed in April 2016.
- A bee project with two bee hives had been initiated. Seventeen patients and eight staff commenced the lecture programme. The Federation of Irish Beekeepers' Associations set up an exam centre in the Central Mental Hospital, thus facilitating the patients in taking the exam, as well as the general public. Twelve patients and eight staff sat the Preliminary Certificate in Bee-keeping and were awarded a certificate in August 2014. The award for best patient education project was awarded at the Irish Health Care Awards.
- There was an active animal husbandry project in which patients participated.
- A physical trainer provided a training programme for patients, both in the gym and in the units, on two days a week.
- Additional music classes for guitar and drums had commenced and patients formed their own band, which performed at the hospital garden party.

2.10 Resident Interviews

Five patients spoke with the inspection team. Those in Laurel Lodge (the hostel) liked the freedom to move around the grounds, and the environment of the hostel. The other patients raised confidential matters.

2.11 Feedback Meeting

A feedback meeting was held on 8 October 2015. It was attended by:

The Registered Proprietor nominee
The Acting Clinical Director
The Director of Nursing
The Hospital Manager
The interim Principal Social Worker

This meeting served to facilitate the provision of provisional feedback regarding the findings of the inspection together with an opportunity for representatives of the service to clarify any issues arising from the inspection.

3.0 Inspection Findings and Required Actions - Regulations

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

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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

Inspection Findings

Processes: The process for identifying patients for administration of medication was in the Control, Management and Administration of Medication Policy. The Admission Policy stated that photographs of each patient should be taken as soon as possible.

Training: As part of the induction process, new staff were paired with an experienced staff member to gain familiarity with the patients.

Monitoring of Compliance: No monitoring of the process of identification of patients was undertaken.

Evidence of Implementation: Photographs, names and date of birth were used as identifiers, which was appropriate to the location in which the patients were accommodated.

Compliance Rating:

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

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: There were processes in place with regard to food and nutrition in the approved centre.

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

Monitoring of Compliance: Monitoring of the processes regarding food and nutrition was carried out in the approved centre.

Evidence of Implementation: Patients' intake of food was monitored and patients' weights were recorded. Nutritional assessment tools were not used to assess nutritional status. Where special diets were indicated, multidisciplinary input was documented. Menus were reviewed and approved by a dietician and the food was nutritional, wholesome and well presented. Special diets were supplied when indicated by clinical needs or religious or cultural requirements. There was a water filter system in each unit. There was patient input into menus through meetings with the catering manager.

Compliance Rating:

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

3.6 Regulation 6: Food Safety

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

Inspection Findings

Processes: There was a policy with regard to food safety which was dated February 2012. It did not contain roles and responsibilities of staff, the processes for food preparation, food handling, food storage or disposal of food. The food safety legislation requirements were not documented in the policy. The processes for management of catering and food safety equipment or monitoring of food safety were not included in the policy. The training of relevant staff was documented in the policy.

Training: All catering staff were trained in Hazard Analysis Critical Control Points (HACCP). However, the staff of the company that transported food and, in one unit, transferred food to hot ovens, had not received HACCP training.

Monitoring of Compliance: No monitoring of the food safety processes had been carried out. Catering staff were developing a menu plan to identify potential allergen food stuffs.

Evidence of Implementation: Dining areas were of adequate size. Unit 7 had a new kitchen and dining area. There were hand washing facilities in all relevant areas. Some staff used protective clothing. However, catering staff did not wear hair nets. Catering staff were observed by the inspection team not to be wearing gloves while handling food. The main kitchen was clean, with good storage and an adequate size. The kitchen on unit 4 was not clean. Fridges were used for food only and food temperatures were recorded. All crockery and cutlery were plastic as laid out by the approved centre's policy. Disposal of food waste was observed to be in line with food safety guidelines. There was evidence that the Environmental Health Officer's report, which outlined deficits, was acted upon.

The approved centre was deemed to be non-compliant – poor achievement as a high standard of hygiene was not achieved. This was evidenced by the lack of hygiene in some kitchen areas and the fact that staff did not wear hairnets and gloves when handling food.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.6 Regulation 6: Food Safety

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

Date received	*18th November 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. All kitchen staff have received a letter informing them of their statutory responsibility to wear head covering and gloves at all times when handling food Post-Holder(s):Catherine Bennett catering manager	Food Safety and Food Handling	Visual inspections by Catering Manager and provide six monthly report to senior management team	Reasonable	Letters already sent First report in Quarter 1
2. Deep clean of kitchen on unit 4 John Thompson Review SOP with Emerald cleaning Post-Holder(s):Pauline Gill				Quarter 4 2015 Quarter 1 2016
3. Letter sent to Emerald requesting that the members of staff allocated to meal delivery are HACCP trained	*training for non HSE staff moving transferring food trolleys.*	Provision of certificates and annual audit to ensure standards are maintained	Yes	Quarter 1 of 2016

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There was a statement on the use of night clothes in the approved centre which had been due for review in 2012. Staff were able to articulate the processes in relation to clothing.

Training: Staff were aware of the requirements and restrictions in regard to clothing.

Monitoring of Compliance: There was no monitoring of the processes with regard to clothing, apart from individual clinical decisions about the wearing of night clothes by patients.

Evidence of Implementation: All patients were encouraged to take responsibility for their own clothing and laundry. Emergency clothing was obtained by applying to a comfort fund. Patients were encouraged to purchase their own clothes. There was a stock of emergency clothing in the admission units. There were lockers in each bedroom but these were small with limited storage space. Some lockers were missing doors.
All patients wore day clothes.

Compliance Rating:

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

3.8 Regulation 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy with regard to patients' personal property and possessions. The processes for communicating with patients about their entitlement to bring possessions into the approved centre, recording and managing property, access to property by the patient, returning property on discharge and monitoring of the processes were in the policy. There was no reference to staff training in the policy.

Training: Staff were aware of the policy and had received training in management of personal property and possessions at the induction process.

Monitoring of Compliance: No monitoring of the processes with regard to personal property and possessions was carried out.

Evidence of Implementation: A property list was documented at the time of admission of the patient. Restrictions on bringing into hospital or keeping possessions was discussed with the patient. There was a safe for patients' valuables. Two nurses oversaw and documented the lodging and taking out of monies by the patient from the safe. In Unit B, patients had individual labelled boxes for some of their possessions and did not have access to all possessions due to security considerations.

Compliance Rating:

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

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There were processes in place in relation to the provision of recreational activities.

Training: There was a trained recreational nurse who co-ordinated recreational activities for the patients. Staff showed an awareness of the requirement to provide recreational activities and had signed that they had read and understood the policy.

Monitoring of Compliance: There was an audit of the process of providing recreational activities.

Evidence of Implementation: Each patient had an individual programme of activities and there was a timetable displayed in each unit. Each patient had a risk assessment which was reviewed prior to engaging in activities. Recreational activities included walking, gardening, animal husbandry, table-tennis, books, DVDs, games, a film club and social evenings. Each unit had an outdoor space and there was an extensive garden. Attendance at recreational activities was recorded.

Compliance Rating:

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

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: There was a policy with regard to religion. This outlined the processes in facilitating the practice of patients' religion.

Training: Staff were aware of the processes in place to facilitate the practice of religion.

Monitoring of Compliance: Monitoring of the processes involved in facilitating religion was not carried out.

Evidence of Implementation: There was a chaplaincy service to the approved centre. A list of ministers of different faiths was available. Patients could attend Mass in a chapel in the hospital grounds. Religious affiliation was recorded in the individual care plan.

Compliance Rating:

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

3.11 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 with regard to visits. Risk assessment of patients prior to receiving visitors was outlined in the policy as were restrictions on visiting. The accommodation of child visitors in a special area was included in the policy. The requirement for all visitors to identify themselves to staff at the gate of the hospital was included. Regulations and security requirements for visitors were contained in the policy.

Training: Staff were trained in the process with regard to visitors and in child protection guidelines.

Monitoring of Compliance: The policy was reviewed every three years.

Evidence of Implementation: Visiting times were displayed during visits in the visiting hall and also in the patient information booklet. There were daily visiting times in the evening from Monday to Thursday and during the day on Friday, Saturday and Sunday. There was a specific area for children visiting.

Compliance Rating:

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

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: There was a policy with regard to communication and the roles and responsibilities of staff were defined. The limits with privacy in this forensic setting were outlined in the policy. The requirement for risk assessment with regard to communication, staff awareness of the processes and monitoring of communication were included in the policy. There was no reference in the policy to access to interpretative services.

Training: Staff training in communication processes was completed as part of the induction programme.

Monitoring of Compliance: There was no monitoring of the processes of communication carried out.

Evidence of Implementation: Individual risk assessments with regard to communication were carried out. Staff examined all incoming and outgoing mail as outlined in the approved centre policy. There were phones for patients in all units.

Compliance Rating:

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

3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy in relation to searches which outlined the roles and responsibilities and the process of searching patients. The policy included the requirement for respect for patients' privacy and dignity and the requirement to obtain consent prior to a search. It contained the process for finding illicit substances or items. The policy did not contain the requirement for an individual risk assessment prior to a search, communication processes with the patient or staff training.

Training: Staff received training in conducting a search during the induction programme.

Monitoring of Compliance: No monitoring of the process of searching patients was carried out.

Evidence of Implementation: Three clinical files of patients who had been searched were examined. There was no documented individual risk assessment of the patient carried out prior to a search taking place. There was no record in the clinical file as to whether consent for searches was sought. It was not documented in the clinical file whether the patient was informed of the reason for the search. Staff reported one or two nurses carried out the search; only one nurse signed the clinical file that a search had taken place. Searches were carried out by the same gender nurse and in the privacy of the patient's bedroom.

The approved centre was not compliant with this Regulations as (1) there was not always a minimum of two appropriately qualified staff in attendance at all times when searches were being conducted; (b) there was no record that the resident being searched was

informed of what was happening and why and (3) there was no record as to whether consent was sought from the resident prior to being searched.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.13 Regulation 13: Searches

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

Date received	*8th December 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1.preventative A clinical practice form in relation to searches is been developed which includes risk assessment Post-Holder(s):David Timmons	Individual risk assessment and consent	Searches will be monitored at the SMARG Meeting	Yes	Jan 2016
2.Corrective & Preventative: Policy review with input from the Advocacy service and service users Policy group to forward revised policy to SMT for approval Post-Holder(s):Donal O Malley	The policy on Searches will be revised (with the involvement of residents) to include a requirement for: -Individual Risk assessment, where appropriate -Guidelines for clear documentation of search before and after - Communication of search to residents - Training for staff	Documented in Updated policy SMARG meeting	Review of Policy in consultation with residents	Quarter 1 2016

3. Corrective: Revised Search Policy will make reference to staff training in Induction Post-Holder(s):Donal O Malley	Revision of Search Policy	SMARG Meeting Documented in policy	Clear and identifiable	Quarter 1 2016
Consent for searches is always sought but in the interest of ensuring a safe environment searches without consent will be carried out David Timmons		Monitored at SMARG Meeting	Yes	Quarter 1 2016
Two staff always carry out searches as per Policy this is to protect both patients and staff David Timmons		Security register clinical notes	Yes	Quarter4 2015

3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There were two policies in relation to care of the dying. One was entitled *Death of a Detained Patient* and the second was *Care of the Dying Patient in Hospital*. The policies contained the processes at the end of life in relation to patients' religious and cultural needs, privacy, propriety and dignity, accommodation of the patient's family, supports offered to staff and other patients and the event of a sudden death. A flow chart outlined the processes involved in informing other agencies in the event of a death. There was no reference to Do Not Attempt to Resuscitate Orders in the policies.

Training: Staff were aware of the policy and processes in relation to care of the dying.

Monitoring of Compliance: There had been one death of a patient since the previous inspection in August 2014. This was monitored through root cause analysis.

Evidence of Implementation: As no patient required end of life care, evidence of implementation of this process was not inspected. The approved centre notified the Mental Health Commission of the death of the above patient within 48 hours.

Compliance Rating:

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

3.15 Regulation 15: Individual Care Plan

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

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

Inspection Findings

Processes: There was a policy in relation to individual care plans (ICPs). The process for developing an ICP was detailed as were time-lines for achieving this. The content of the ICP was in the policy. The policy stated that the ICP should be developed "collaboratively" with the patient. The requirement for auditing the ICPs was in the policy. However, it did not contain the requirement for staff training.

Training: Staff had received training as part of their induction programme.

Monitoring of Compliance: An audit of ten ICPs had been completed.

Evidence of Implementation: The clinical files of 26 patients were examined. All contained an ICP. There was evidence that the patients had input to their ICPs and they received a copy. Each patient had a key worker.
All patients had an "initial care plan" which was completed by the consultant psychiatrist within 24 hours. This did not contain goals, interventions or resources. A case conference, which was attended by the patient, carers and the multidisciplinary team, resulted in a Treatment, Care and Risk Plan. This care plan contained needs, interventions and resources but did not contain goals.
The care plan was reviewed weekly and the patient developed "achievable goals" with his/her keyworker for this review, but no goals were outlined in the documents titled *Individual Care Plan* and *Treatment, Care and Risk Plan*.

As the individual care plan did not contain goals, as required in these Regulations, the approved centre was deemed non-compliant, poor achievement, with a moderate risk rating.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.15 Regulation 15: Individual Care Plan

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

Date received	*19th November 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1.Corrective: Ensure that all current achievable goals are attached to the care plan document Post-Holder(s): All staff	Format of Individual Care Plan	Care [plan Audit	Reasonable	December 2015
2. Preventative: A new care plan template has been developed each team are currently using the template as a pilot and will feedback to the care plan review team Post-Holder(s): Dr Brenda Wright	Individual Care Plan	Care plan Audit	Reasonable	Quarter 12016
3. Corrective: ICP Policy will be revised to reference staff training on Induction Post-Holder(s):	The training of Staff on Induction will be detailed in revised ICP Policy	Revised Policy will be available	Clear and attainable	Quarter 1 2016

3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: There was a policy in relation to therapeutic services and programmes. This contained the processes in relation to the provision of therapeutic services and programmes. It did not include the resource requirements.

Training: All staff providing therapeutic services and programmes were trained in the therapies being delivered.

Monitoring of Compliance: An audit of nurse-led therapies had been completed.

Evidence of Implementation: Each patient had a needs assessment and was provided with therapies according to those needs. Each patient had an individual programme of therapies and these were time-tabled. Therapeutic services and programmes were outlined in each patient's ICP. There were a number of locations in the approved centre where therapies were conducted. Therapeutic services and programmes included nutritional programmes, cognitive behavioural therapy (CBT), literacy, education, Wellness Recovery Action Plan (WRAP), Art, music and physical therapy.

Compliance Rating:

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

3.17 Regulation 17: Children's Education

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

There had been no child admitted to the approved centre since the previous inspection in August 2014. Therefore, this Regulation was not applicable.

Compliance Rating:

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

3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: There was a policy in place with regard to transfer of patients. This policy outlined the processes involved in transferring a patient, including the necessity for continuity of care. It outlined the requirement for a referral letter, individual risk assessment, personal possession management and emergency transfer. It did not contain reference to patient privacy and confidentiality, management of patients' medication during transfer, training requirement for staff or monitoring of the transfer processes.

Training: Staff were aware of the transfer processes.

Monitoring of Compliance: No monitoring of the processes for transfer of patients was carried out.

Evidence of Implementation: Three clinical files of patients who had been transferred were examined. In two cases, the progress notes outlining the transfer process of that patient could not be located by the inspection team or staff. The third clinical file contained all relevant details about the transfer. However, no copy of referral letter was maintained in the clinical file. As this was an emergency transfer, pre-transfer information was not communicated with the receiving facility.

Compliance Rating:

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

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

Inspection Findings

Processes: There was no policy with regard to general health. The primary care nurse was able to articulate the process of providing general health care. There was a policy in relation to medical emergencies. This policy outlined training requirements and management of emergency equipment. Monitoring and continuous improvement requirements in relation to medical emergency processes was not in the policy.

Training: All staff were trained in Basic Life Support. The primary care nurse was a trained practice nurse.

Monitoring of Compliance: Uptake of screening and physical health were recorded and audited by the primary care nurse. Apart from this, no monitoring of the processes of providing general health care was carried out.

Evidence of Implementation: Two general practitioners provided five-and-a-half hours of general health assessment and care each week and there was a primary care nurse in the approved centre. A clinic room was available, which offered privacy during consultations. Patients' physical health status was recorded in a primary care folder and in the ICP documents. Nine clinical files of patients who were in the approved centre for more than six months were examined. All had a physical examination as required by this Regulation. Records of up-take of screening were also available in the clinical file of those eligible for screening programmes. There was a healthy life style choice programme called WANE (Weight and Nutritional Educational Programme). There was also an exercise programme with a trained physical instructor. A dentist attended the approved centre weekly. Medical emergency equipment was available in each unit, and was checked weekly.

Compliance Rating:

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

3.20 Regulation 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

Inspection Findings

Processes: There was a policy with regard to giving information to patients. This policy outlined the roles and responsibilities of staff. The processes of giving information to patients at the time of admission, to their representatives and access to advocacy were in the policy. Assessment and reassessment of patients' communication needs, staff training in the process and monitoring of the process were not in the policy.

Training: Training in information-giving was received during the induction programme.

Monitoring of Compliance: There was no monitoring of the process of giving information to patients.

Evidence of Implementation: Each patient had an information folder which contained information about the approved centre, housekeeping arrangements, visiting times, patients' rights, their individual care plans, risk assessments and advocacy availability. Information leaflets were available, if requested, with regard to diagnosis and medication. There was access to interpretative services.

Compliance Rating:

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

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: The patients' right to privacy and dignity was included in policies on seclusion and searching. Staff were able to articulate how they respect privacy and dignity during care and treatment of patients.

Training: No training had taken place with regard to privacy.

Monitoring of Compliance: There was no monitoring of the processes in respecting patients' privacy.

Evidence of Implementation: As the approved centre was a forensic mental health service, not all aspects of patient care and treatment could fully respect patients' dignity due to security requirements.
Each patient had a single room. There were privacy curtains on the observation panel of each bedroom door. There were locks, which could be over-ridden by staff, on the toilet and bathroom doors. Staff were observed to be respectful of patients during the inspection.
Phones for patients were in main corridors in the units 2 and 3, with no privacy. Portable phones were available in the other units. There were notice boards in the main corridors with patients' full names. One patient's individual activities schedules were observed to be displayed on the outside of their bedroom door.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.21 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:

Date received	*8th December 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. Corrective: A review group will be established to review access to telephones in secure facilities Post-Holder(s):Pauline Gill David Timmons	Privacy for phone calls	\Working group to report to SMT on best practice	Yes	Quarter 12016
2. Corrective Remove full names and only put initials At the next tour of Units consult with the patients re usefulness of notice board or not Post-Holder(s):David Timmons Pauline Gill	Names of patients disclosed to other patients	Will be reviewed by SMT on next SMT tour of units	Yes	End of Quarter 4, 2015
3. Corrective: The training of staff in issues pertaining to privacy will be documented in Induction Policy and training records Post-Holder(s): Dónal O'Malley Paul McKenna	Training of staff	Documentation in update policy and training records	Yes	Quarter 1 2016
The timetable has been removed from the outside of the patient's room. We will monitor with the patient any difficulties with not having an easily accessible timetable.	Privacy	As it is an activity timetable and does not contain any medical information should the patient believe that having the timetable available on the	Yes	Completed

Patients MDT		outside of the door acts as a memory aid we will remove his name from the timetable.		

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

Inspection Findings

Processes: Senior management were able to articulate the processes with regard to improving and replacing the premises.

Training: There was no staff training with regard to premises.

Monitoring of Compliance: There was a maintenance log of ongoing issues with the premises.

Evidence of Implementation: The approved centre was 157 years old and the main building retained the features of that era. General hygiene had improved since the previous year although there were still areas such as the laundry room in Unit 2 that were dirty. The kitchens in Unit 2 and 3 were in a poor state, with broken kitchen cupboards. Some windows and walls had peeling paint, although painting had taken place in some units. Plaster was falling from some walls in the main building. There was a hole in the wall in Unit 3. The toilets in Units 2 and 3 were in poor condition. Bedrooms were too small and had little space for storage of personal possessions. The day room in Unit B was cramped and had little space for patients who were there for most of the day. The furnishings in Unit B were scruffy and torn but there were plans to replace them. There was a new kitchen and dining room in Unit 7.

The approved centre was uncomfortably warm, with a temperature in Unit 1 of 24 degrees Celsius on 8 October 2015. The radiators throughout the approved centre were too hot to touch. The staff had no control over the heating in individual units. Both staff and patients complained to the inspection team of the heat in the approved centre.
The outside grounds and patients' garden area was exceptionally well kept and a very pleasant area.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
		X		

3.22 Regulation 22: Premises

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

Date received	*8th December 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
Corrective action Funding has been identified to improve the kitchen on Unit 3 and Unit 2 Post-Holder(s):Mr Patrick Bowe Ms Pauline Gill	Kitchen	Work completed	Yes	Quarter 4 2015
2. Minor capital works plan will be developed to maintain and repair building Post-Holder(s): Pat Bowe Austin ward Pauline Gill				Quarter 4
3.New furniture ordered for Unit B Post-Holder(s): Pauline Gill	Furniture premises	Yes Senior Management will monitor when tour of units	Yes	December 2015
Lack of heating controls and ventilation. The Maintenance department are actively looking to identify if separate heating controls can be provided to individual units. Pat Bowe Maintenance	Premises	Will monitor with regular meeting between SMT and Maintenance department	Will depend on outcome of assessment by maintenance	Quarter 2 2016

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

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

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

Inspection Findings

Processes: There was a policy in place with regard to control, management and administration of medication. The policy covered the ordering, prescription, storage and administration of medication, including self-administration. The policy also included processes in refusing medication and withholding medication. The process for reconciling medication was not included.

Training: Staff involved in management of medication were all trained nursing and medical staff.

Monitoring of Compliance: There was no monitoring of the process of managing medication.

Evidence of Implementation: Twenty-two medication prescription and administration records (MPARs) were examined. Photographs, names and dates of birth were used to identify patients. In ten MPARs, the allergies section was not completed and, in ten MPARs, generic names of medication were not used. Medical Council Registration Numbers (MCRNs) were not used in 16 of the 22 MPARs. This is a breach of the Medical Practitioners Act 2007. One prescription was not signed by the medical practitioner. Medication was reviewed weekly. Storage of medication was in locked presses or in a fridge. The fridge was dirty in Unit B. Otherwise, the storage areas were clean. All unused or out-of-date medication was returned to the pharmacy.

As 16 out of 22 MPARs did not contain MCRNs, which is a breach of the Medical Practitioners Act 2007, the approved centre was deemed non-compliant-poor achievement with this Regulation.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

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

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

Date received	*18th November 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. Corrective Updating of policy on Medication. Post-Holder(s): Dónal O'Malley Joe Scales	The process reconciling medication will be detailed in revised policy	Revised policy	Clear and documented	Quarter 1 2016
2. All medical staff will be written to in relation to MRCRNs numbers and their statutory responsibility Post-Holder(s): Professor Harry Kennedy	Breach of Medical Practitioners Act 2007	Annual Audit	Yes	Quarter 4 2015
3. *Corrective* *New Fridge ordered for Unit B* Post-Holder(s):	Fridge faulty	receipt	Yes	Quarter 4 2015

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a Health and Safety Statement which outlined the processes of health and safety. The roles and responsibilities of staff, compliance requirements in relation to relevant legislation, the risk management process, infection control, medical emergencies and first aid response and the fire management plan were outlined in the policy. There was no falls prevention initiative outlined in the policy.

Training: Staff were trained in incidents and risk management. They were also trained in fire safety, moving and handling patients and objects, food safety, infection control and personal safety at work. They were not trained in falls management.

Monitoring of Compliance: There was no evidence of annual audit in the processes related to health and safety. Incidents were recorded and reviewed at the Risk Management Committee and the Seclusion Monitoring and Review Group. Processes were monitored by the Health and Safety Committee.

Evidence of Implementation: The Health and Safety Statement and a risk register were available in the approved centre. Incidents were reported and reviewed by the Health and Safety Committee, which met monthly. There were two staff safety representatives. Risks were assessed and reviewed by the Risk Management Committee. There was a fire plan which included fire drills for staff. Emergency lighting was in place. There was no emergency plan in place. Some hand washing facilities available but were not in every area due to clinical risks. Clinical waste was managed appropriately. Changing facilities and toilets were provided for staff.

Compliance Rating:

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The processes with regard to CCTV were contained in the observation policy and the CCTV policy. The policies contained all the processes with regard to CCTV apart from the requirement to maintain the CCTV cameras and the disclosure of the CCTV to the Inspector of Mental Health Services or the Mental Health Commission. Although the policy stated that the CCTV could record and the images kept for 30 days, this in fact did not happen.

Training: Staff were not trained in the processes in relation to CCTV.

Monitoring of Compliance: No monitoring of the process in relation to CCTV took place.

Evidence of Implementation: CCTV was used in Unit B, Unit 4 in the seclusion room and in Unit 1 in the seclusion rooms. The monitors were in the corridors although it was stated by management that the staff “have a remote control button to quickly turn off the screen” so that images were not visible to passing patients. The CCTV was disclosed to the inspection team and notices regarding CCTV were prominently displayed. Only nursing staff and care staff monitored CCTV. There was no recording or transmitting of CCTV images.

Compliance Rating:

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

3.26 Regulation 26: Staffing

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

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

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

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

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

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

Inspection Findings

Processes: There was no policy on recruitment of staff specific to the approved centre. However, the approved centre used the generic HSE policy on recruitment and selection. This outlined the roles and responsibilities of staff and the process for recruitment, selection and appointment of staff. The approved centre had an induction policy which contained the process for induction and orientation of staff, staff rota details and staff training. The policies did not contain the required qualifications of training staff, evaluation of training programmes or the monitoring and continuous improvement requirements for staffing process.

Training: All staff were aware of the policies with regard to staffing and induction.

Monitoring of Compliance: Training plans were coordinated by a dedicated assistant director of nursing. Reviews of the training plan were informal. The allocations officer reviewed the levels and skill mix of staff. No other monitoring of the process of staffing was carried out.

Evidence of Implementation: There was an organisational chart of the management structure of the approved centre. The allocations officer managed the staff roster and staff plan. There was a record of the appropriately qualified staff member in charge in each unit. All staff were vetted by an Garda Siochána. Two personnel files were examined. Both contained a job description, qualifications, terms and conditions of employment. Further training records were not in the files. There was a record of training and staff had been trained in Therapeutic Management of Violence (TMV), basic life skills, fire safety, patients' rights, child protection guidelines, first aid and the Mental Health Act 2001. There was no training in infection control or handwashing. An induction programme took place bi-annually for new staff over a two week period and existing staff were invited to attend for refresher courses. Staff performance was assessed during the induction period but no other formal evaluations of staff took place. There were facilities for the training and education of staff. The Mental Health Act, Rules and Regulations were available to all staff in the approved centre.

Compliance Rating:

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

3.27 Regulation 27: Maintenance of Records

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

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

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

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

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

Inspection Findings

Processes: There was no specific policy with regard to maintenance of records for the approved centre. There was an over-arching HSE policy. There was a guideline on documentation specific to the approved centre.

Training: Induction training for staff included training in maintaining records and documentation.

Monitoring of Compliance: There was a logging system of patient records. There was no audit carried out with regard to maintaining records.

Evidence of Implementation: Patients' records were located in a secure area. Only authorised staff had access to the records. Documentation was in accordance with the HSE records policy. The records were in good order, had a unique identifier and contained relevant information. The Environmental Health Officer's report, the Fire Officer's report and the Health and Safety report were kept in the approved centre.

Compliance Rating:

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

3.28 Regulation 28: Register of Residents

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

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

Inspection Findings

An up-to-date register of patients was maintained in the approved centre which was compliant with Schedule 1 to the Regulations.

Compliance Rating:

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

3.29 Regulation 29: Operating Policies and Procedures

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

Inspection Findings

Processes: The approved centre used the HSE Procedure for Developing Policies, Procedures, Protocols and Guidelines. Within this, the roles and responsibilities of staff and the processes of development, approval and review of policies were included. Training of staff on policies and procedures and dissemination of policies was not included.

Training: There was no training provided in relation to updating and reviewing policies and procedures.

Monitoring of Compliance: Each policy was reviewed every three years. The policy on physical restraint, which should be reviewed on an annual basis, was out of date. There was no other monitoring of the processes of developing, approving, disseminating and reviewing policies.

Evidence of Implementation: There was a Policy Committee which met every three months. Sub-committees were formed to review specific policies. All policies were accessible by staff, who were notified of any updates. The format of the policies was standardised.

Compliance Rating:

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

3.30 Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

*Processes: S*taff were able to articulate the processes involved in Mental Health Tribunals.

Training: Staff had received training in the induction programme in the Mental Health Act 2001.

Monitoring of Compliance: Monitoring of Mental Health Tribunals was not carried out.

Evidence of Implementation: There was a facility for holding Mental Health Tribunals. Patients were accompanied by staff when attending their Mental Health Tribunal. Information regarding Tribunals was given to the patients beforehand and they were made aware of the outcome of their Tribunal. Each patient had access to a legal representative.

Compliance Rating:

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

3.31 Regulation 31: Complaints Procedure

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy in place with regard to complaints. The policy outlined the processes relating to the management of complaints, including confidentiality, time-lines, communication, documentation, advocacy and appeals process. There was no reference to staff training in complaints processes or monitoring of the processes.

Training: Staff received training in the complaints process during their induction programme and this was documented.

Monitoring of Compliance: There was monitoring of the processes of managing complaints. A record of all complaints was kept locally and a returns sheet sent to the consumer affairs department for inclusion in national statistics. There were feedback meetings every month between patients and senior management.

Evidence of Implementation: There was a nominated person to investigate complaints. The complaints procedure was displayed on the noticeboards in each unit, with the name of the nominated complaints officer. Notices about advocacy services were clearly displayed. There was a complaints log and there were time-lines for each stage of the process. There was evidence of communication between the nominated person dealing with complaints and the complainants, and the complainants received communication about the outcome of their complaints. The complaints were discussed at MDT meetings with the consent of the complainant.

Compliance Rating:

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

3.32 Regulation 32: Risk Management Procedure

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

Inspection Findings

Processes: There was a policy with regard to risk management. The policy contained the processes for assessment of risk in suicide and self-harm, absent without leave, assault and injury to staff and patients. Risks in the approved centre were identified in the policy, along with control measures. Risk governance was outlined. The policy outlined that the risk management committee was responsible for review, audit, monitor and learning from incidents. *Children First* guidelines were referenced in the policy.

Training: Risk management training for staff was completed during the induction programme.

Monitoring of Compliance: Incidents were recorded and reviewed monthly by the Seclusion Monitoring and Review Group and the Risk Management Committee.

Evidence of Implementation: Two safety representatives were allocated to the approved centre. There was a risk governance structure in place. Individual risk assessments and management plans were completed for all patients and reviewed at MDT meetings. A risk register was available and incidents were recorded. There were monthly meetings of the risk management committee. The approved centre was finalising a major incident policy.

Compliance Rating:

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

3.33 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 HSE State Claims Agency had issued a State Indemnity Confirmation Statement and this was available to the inspection team.

Compliance Rating:

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

3.34 Regulation 34: Certificate of Registration

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

Inspection Findings

The Certificate of Registration was displayed prominently in the main hall of the approved centre.

Compliance Rating:

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

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

Section 59
(1) "A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable or unwilling to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules."

ECT was not administered in the approved centre and no patient was receiving ECT in another approved centre at the time of inspection.

Compliance Rating:

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

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

Inspection Findings

Processes: There was a policy in place with regard to seclusion. The roles and responsibilities of staff with regard to initiating and reviewing seclusion were evident. The requirement for risk assessment, communication with the patient, ordering of seclusion and observation of the patient during seclusion were contained in the policy. However, the policy stated that a medical review during the night is on a needs-basis rather than every four hours as required by these Rules. There was no reference in the policy to the provision of information about seclusion for the patient.

Training: Staff were trained in seclusion, the alternatives to seclusion, the Mental Health Act 2001 and the Therapeutic Management of Violence (TMV). There was no specific training for seclusion of children, but all staff had received training in *Children First* guidelines.

Monitoring of Compliance: Seclusion was reviewed and monitored by the Seclusion Monitoring and Review Group, which met on a monthly basis.

Evidence of Implementation: The clinical files of eight patients who had been secluded were examined. There was evidence that patients had been assessed prior to initiating seclusion. These assessments included risk assessments. Nursing observations and reviews took place at 15 minutes and two hourly intervals respectively. Medical reviews took place every four hours except between the hours of 00:00 to 08:00, which was not in compliance with the Rules. Consultant psychiatrist reviews were documented. Alternatives to seclusion were considered. Five patients had been secluded for more than eight hours and the extension orders were completed. There was documented evidence that the patients had been informed of the reasons for seclusion and the actions required to terminate seclusion. Next of kin were informed of the episode of seclusion; if not, the reason was documented. The seclusion episode was reviewed by nursing and medical staff as soon as possible after the seclusion episode. There was no specific seclusion care plan.

Seclusion facilities in Unit 1 were small and antiquated. The noise of the heating system was loud. There was access to a toilet beside the seclusion rooms. The seclusion rooms in Unit B were small. The toilet was located in the room. Protective clothing was worn by patients and was documented.

The seclusion register was correctly completed. However, three seclusion orders were not signed by the consultant psychiatrist as required by these Rules. Notification was made to the Mental Health Commission that there were two seclusion episodes exceeding 72 hours.

CCTV was operational in the seclusion rooms in Unit 1, Unit B and Unit 4. There was signage indicating its use. In Unit B, the monitor was located in a corridor to the patients' bedrooms. Staff reported that the monitor was switched off if patients were passing.

As four-hourly medical reviews of patients, required by these Rules, were not done between 00:00 and 08:00, the approved centre was deemed to be non-compliant – poor achievement.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

4.2 Section 69: The Use of Seclusion

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

Date received	*18th November 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. Corrective: Seclusion Policy and Communication with Patients Policy will be adapted to reflect practice of describing seclusion to residents Post-Holder(s): Dónal O'Malley	Provision of information on seclusion	SMARG Updated policies	Good	Quarter 1 2016
2 Senior Management Team to review Seclusion Policy Post-Holder(s):	Night medical reviews	Audit	Yes	Quarter 4 2015

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

Inspection Findings

Processes: There was a policy with regard to mechanical restraint that was reviewed annually. The policy outlined the processes involved in mechanical restraint. These included the requirement that the patient was to be informed of mechanical restraint, the requirement for risk assessment, that mechanical restraint was to be documented in the ICP, the mechanical restraint register requirements and the documentation of mechanical restraint in the clinical file.

Training: Staff were trained in mechanical restraint during the induction programme, which included gender and cultural sensitivity.

Monitoring of Compliance: An annual audit of mechanical restraint took place and it reviewed at the Seclusion Monitoring and Review Group meetings every month.

Evidence of Implementation: Handcuffs were used in some cases during transport to and from the approved centre. The use of mechanical restraint was reviewed at the MDT meetings and documented in the clinical files. The consultant psychiatrist was made aware of the use of mechanical restraint and this was recorded in the clinical file. The mechanical restraint register was completed correctly. Information was provided to the patient about the use of mechanical restraint. Mechanical restraint was documented in the clinical file.

Compliance Rating:

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

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

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 an undated and unsigned policy with regard to consent to treatment. It did not contain roles and responsibilities of staff and the process for obtaining patients' consent for treatment. It contained the process for assessing capacity.

Training: Staff were trained in the Mental Health Act 2001, including Part 4 of the Act, as part of their induction programme.

Monitoring of Compliance: There was no monitoring of compliance to the process of consent to treatment.

Evidence of Implementation: Nine patients' MPARs were examined. All patients had either consented to treatment in writing or the continued administration of medicine was authorised in a Treatment without Consent Administration of Medicine Form (Form 17) by another consultant psychiatrist following referral by the treating consultant psychiatrist. All consent forms specified the medication to be administered.

Compliance Rating:

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

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: There was a policy with regard to physical restraint but this had not been reviewed annually as required by this Code of Practice. Identification of those who could initiate physical restraint and training requirements for staff were contained in the policy. The requirement to give information to the patient during physical restraint was not in the policy

Training: All staff were familiar with the restraint policy and procedure. The training programme for physical restraint includes alternatives to physical restraint, de-escalation and breakaway techniques. A record of attendance at training was maintained.

Monitoring of Compliance: There was no evidence of an annual audit of physical restraint. However, physical restraint was reviewed and discussed at the Seclusion Monitoring and Review Group meetings, which were held monthly.

Evidence of Implementation: Each patient had a risk assessment. Physical restraint was used in a proportionate and professional manner. Minimal force was used. De-escalation was used prior to physical restraint. The Clinical Practice Form for physical restraint was completed correctly. Patients were informed of the reasons and likely duration of the physical restraint. The episodes of physical restraint were recorded in the clinical file. Next of kin were informed of the episodes of physical restraint and the episode of physical restraint was discussed with the patient following its termination. Consultant psychiatrist and MDT review was documented in the clinical files.

As the policy for physical restraint was not reviewed annually as required by this Code of Practice, the approved centre was deemed non-compliant.

Compliance Rating:

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

Risk Rating:

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
X				

6.1 The Use of Physical Restraint

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

Date received	*18th November 2015*			
CAPAs	**Specific**	**Measureable**	**Achievable & Realistic**	**Time-bound**
*Define the action **and** state if it is corrective or preventative **and** state post-holder(s) responsible*	*Define the area of non-compliance addressed by this CAPA*	*State method of evaluation and monitoring of outcome*	*State feasibility of action*	*State time-frame for completion of action*
1. Corrective Policy on Physical Restraint will be updated annually Post-Holder(s):	Annual update of policy	Annual review of policies	Clear and identifiable	Quarter 4 , 2015

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.

Children had not been admitted to the approved centre since the previous inspection in August 2014.

Compliance Rating:

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

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

Inspection Findings

Processes: There was a risk management policy in place. Processes were in place for notification of deaths and incident reporting. The risk manager was identified in the policy. Roles and responsibilities of staff were outlined in the policies.

Training: Staff were aware of the process of death and incident reporting.

Monitoring of Compliance: Incidents were reviewed through the Risk Management Committee. There were no audits with regard to the process of death and incident reporting.

Evidence of Implementation: One death had taken place since the previous inspection in August 2014. The death was notified to the Mental Health Commission. The approved centre was compliant with the statutory requirements of Regulation 32 Risk Management Procedures. Incident reports were recorded and available for examination by the inspection team. Summaries of incidents were sent to the Mental Health Commission every six months.

Compliance Rating:

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

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

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

Inspection Findings

There were 16 patients with a diagnosis of mental illness and intellectual disability in the approved centre.

Processes: There was no current policy in relation to mental illness and intellectual disability. However, a new service for patients with mental illness and intellectual disability was due to start in November 2015 and in the meantime the policy was in draft form.

Training: The draft policy stated that the training of staff will commence when the new service commences.

Monitoring of Compliance: As the new service for patients with mental illness and intellectual disability had not yet commenced, monitoring of the processes had not taken place.

Evidence of Implementation: Restrictive practices were in line with the approved centre's policies on seclusion, mechanical restraint and physical restraint. Each patient had an ICP. There was a key worker system in place. Patients had an assessment of their communication needs as well as an occupational therapy assessment of cognition. There was a behaviour plan in place for patients.

Compliance Rating:

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

6.5 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.

There were no voluntary patients in the approved centre. The approved centre did not administer ECT.

Compliance Rating:

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

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

Inspection Findings

Processes: There were policies in the approved centre with regard to admission, transfer and discharge and the processes were outlined in each policy. The policies outlined the roles and responsibilities of staff, the process involved in involuntary admission and emergency transfer. The discharge policy included the requirement for follow-up care and the role of the social worker in obtaining accommodation. The policies did not contain reference to staff training.

Training: Staff were aware of the processes in relation to admission, transfer and discharge.

Monitoring of Compliance: Audits with regard to admission had been completed.

Evidence of Implementation:
Admission: Two clinical files of patients who had been admitted were examined. A full assessment of the patients was carried out prior to admission. The patients were admitted in their best interests and because they were suffering from a mental illness. In the case of one patient admitted, it was not possible to carry out a full admission assessment due to clinical reasons. The other patient had a full assessment on admission. The patients had an individual care plan and had an information folder. Patients had an MDT assessment following admission. The clinical files were well maintained and stored securely.
Transfer: The clinical file of one patient who was transferred was examined. The transfer was in the best interests of the patient and the decision to transfer was made by the consultant psychiatrist and recorded in the clinical file. The clinical file did not record contact with the receiving facility, next of kin, discussion with the patient about the transfer or a risk assessment prior to transfer. There was no copy of the referral letter in the clinical file. Two staff accompanied the patient while on transfer.
Discharge: Patients were discharged in compliance with the Code of Practice.

Compliance Rating:

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