Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME:	O'Connor Unit, St Finan's Hospital
IDENTIFICATION NUMBER:	AC0050
APPROVED CENTRE TYPE:	Rehabilitation Unit
REGISTERED PROPRIETOR:	Health Service Executive
REGISTERED PROPRIETOR NOMINEE:	Ms Gretta Crowley
MOST RECENT REGISTRATION DATE:	1 March 2014
NUMBER OF RESIDENTS REGISTERED FOR:	32
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	12, 13 October 2015
PREVIOUS INSPECTION DATE:	3 July 2014
CONDITIONS ATTACHED:	Yes
LEAD INSPECTOR:	Ms Lydia Martin
INSPECTION TEAM:	Mr Damien Lanigan
THE INSPECTOR OF MENTAL HEALTH SERVICES:	Dr Susan Finnerty MCN 009711 (Acting)

Contents

1.0 Mental Health Commission Inspection Process

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

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

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

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

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

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

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

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

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health Commission has the authority to initiate escalating enforcement actions up to, and including,

removal of an Approved Centre from the Register and the prosecution of the Registered Proprietor.

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

The approved centre was located on the grounds of St Finan's Hospital in Killarney. The O' Connor Unit was a mental health recovery unit and consisted of two units, West Wing (female) and East Wing (male) which catered for up to 32 residents. There were 32 residents in the unit at the time of inspection, two of whom were detained.
The unit and grounds of St. Finan's Hospital were well signposted from the road. The single –storey building, built in the 1970s, was in need of repair, both inside and out. The O' Connor Unit was due to move to a new building in Spring 2016 which would cater for up to 40 residents.

The entrance to the East Wing was open on arrival. Access was gained between East and West Wings by entering a code at the door. These doors remained open during meal times as there was a shared dining room between the two wings.
Admissions to the O' Connor Unit were done by planned transfer from the Acute unit in Kerry General Hospital in Tralee.

Sleeping accommodation mainly consisted of 3 and 4 bedded rooms with only 4 single rooms on the East Unit. Toilets and shower facilities were shared between many residents.
The service had one condition attached to its registration pertaining to direct admissions. The service was in compliance with this condition.

2.2 Governance

The service provided copies of their Business Meeting minutes. These minutes showed evidence of regular senior management meetings. One of the main items at the meetings reflected the new unit and the move in 2016. There was an organisational chart and clear governance structures and processes in place. The senior management team met on a monthly basis.

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: 12th Oct 2015 (0915h-1730h) to: 13th Oct 2015 (0830h-1730h)

2.4 Outstanding issues from previous inspection

The previous inspection of the O' Connor Unit on 3 July 2014 identified that the approved centre was not fully compliant with the following Regulations, Rules, Act and Codes of Practice listed below. The compliance rating achieved for each of these in the 2015 inspection is presented below.

Regulation/Rule/Act/Code	Inspection Findings 2015
Regulation 8: Residents' Personal Property and Possessions	Compliant
Regulation 13: Searches	Compliant
Regulation 21: Privacy	Compliant
Regulation 23: Ordering, Prescribing, Storing & Administration of Medicines	Non-Compliant
Regulation 24: Health and Safety	Compliant
Regulation 26: Staffing	Compliant
Regulation 29: Operating Policies and Procedures	Compliant
Regulation 31: Complaints	Non-Compliant
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.	Compliant
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	Non-Compliant
Guidance for persons working in Mental Health Services with People with Intellectual Disabilities	Non-Compliant
Code of Practice on the Use of Physical Restraint in Approved Centres	N/A

2.5 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 19: General Health	Low
Regulation 22: Premises	High
Regulation 23: Ordering, Prescribing, Storing & Administration of Medicines	Moderate
Regulation 31: Complaints Procedure	Moderate
Regulation 32: Risk Management Procedure	Low
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	Moderate
Guidance for persons working in Mental Health Services with People with Intellectual Disabilities	Moderate

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

2.6 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 5 : Food and Nutrition
Regulation 6 : Food Safety
Regulation 7: Clothing
Regulation 9: Recreational Activities
Regulation 15: Individual Care Plans
Regulation 20: Provision of Information to Residents
Regulation 27: Maintenance of Records

Regulation 28: Register of Residents
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals
Regulation 33: Insurance
Regulation 34: Certificate of Insurance

2.7 Areas of good practice identified on this inspection

- There was a weekly therapeutic programme facilitated by the nursing staff, art teacher and occupational therapists. Residents were facilitated to choose activities that met their interests and hobbies. Nursing staff, mental health care assistants and the occupational therapist assisted if residents wanted to go to the library, post office etc. on a daily basis using the Approved Centre bus or encouraging physical activity by walking to town. This gave residents an opportunity to engage in a range of activities aimed at promoting physical and psychosocial functioning. Resident uptake was observed to be good.
- The new Information Booklet for residents and family was comprehensive in its scope and oriented residents to all aspects of the approved centre.

2.8 Reporting on the National Clinical Guidelines

All reporting on infection control was completed through the Clinical Nurse Manager.
Two safety statements, one for East Wing and one for West Wing, had procedures on reporting outlined in the statements.

2.9 Resident Interviews

Over the two days, residents were greeted by inspectors during the course of the inspection, and were invited to meet with the inspectors if they wished. The inspection team also visited the dining room and talked with residents during their main meal of the day. The residents were open about the move to the new centre next year. Most feedback was concern about the 'smoking ban' in the new building.

2.10 Feedback Meeting

The inspection finished on day two with a feedback meeting between the inspection team and the senior management team of the approved centre. The feedback meeting was part of the inspection process and enabled issues of clarification to be dealt with. Senior managers form the approved centre who attended the feedback meeting included the Assistant Clinical Director, the Director of Nursing, Business Manager, Area Administrator, Practice Development Co-ordinator, Assistant Director of Nursing, three Clinical Nurse Managers, Principal Psychologist, Senior Occupational Therapist, Occupational Therapist and the Principal Rehab Social Worker.

The members of the senior management team responded to queries and feedback from the inspection team and provided an account of the current challenges and achievements of the approved centre especially around the premises and the limitations of lack of space.

The inspection team discussed the issues that came up whilst talking to residents in relation to the new move and the 'smoking ban'. The Senior Management Team discussed that smoking cessation training was being held in the centre that day to help staff prepare residents for moving and that they were going to involve residents in the planning of the move along with their families.

3.0 Inspection Findings and Required Actions - Regulations

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

3.1 Regulation 1: Citation
Not Applicable

3.2 Regulation 2: Commencement
Not Applicable

3.3 Regulation 3: Definitions
Not Applicable

3.4 Regulation 4: Identification of Residents

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

Inspection Findings

Processes: There was a policy in place on the Identification of Residents. The policy outlined the roles and responsibilities of staff and laid out the identifiers that should be used within the West and East Wings. The policy also included consent form for photographs, audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: There was no specific training but all staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: There was no formal monitoring of the processes. However, photographs were updated regularly to ensure the identifiers were up to date.

Evidence of Implementation: Photographs, dates of birth, name and MRN were used to identify residents when receiving medication or other services The inspection team observed the clinical files with photographs, date of birth, name and medical record number (MRN) included in the medical file. Photographs and names were used to identify residents during the administration of medication.

Compliance Rating:

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

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: The O' Connor Unit had a policy in place which was reviewed in April 2015. The policy identified the roles and responsibilities for all staff.

Training: There was no specific training but all staff were responsible for reading and adhering to the policy which they received from their line managers

Monitoring of Compliance: Nursing staff monitored food intake for residents that required one.

Evidence of Implementation: The dining room was a shared space for both the West and East Wings. The room was bright with plenty of space for all residents. There was a supply of condiments and access to a microwave and toaster for residents. Meals were prepared in the kitchen in St. Columbanus, the main hospital building located near the O' Connor Unit and was delivered to the unit and served through a hatch between the pantry and dining room. A menu was displayed in the dining room and there was a choice of meals daily with special diets being catered for. Water coolers were observed throughout the unit. Between meals, snacks and hot drinks were provided by the catering assistants. The final snack was at 1930h.
There was a monthly (and weekly for some residents) weight chart for each resident in the clinical record. Where a resident had need for a special diet, for example, soft diet or diabetic diet, this was monitored by nursing staff and recorded in the residents 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	

3.6 Regulation 6: Food Safety

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

Inspection Findings

Processes: The O'Connor Unit had a policy on food safety outlining all the roles, responsibilities and procedures for the staff and unit. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All new staff received induction training to the policy and procedures set out in the policy. All catering staff received training in the safe handling of food *(HACCP Hazard Analysis and Critical Control Points training).*

Monitoring of Compliance: Food safety audits were completed on a weekly basis in each unit. The audits were signed off by the household manager. Temperature logs, cleaning schedule and dining room cleaning schedules were all inspected and had a defined schedule.

Evidence of Implementation: The inspection team visited the servery kitchen and met with the kitchen assistants, inspected the food safety records and spoke with the catering manager.

The dining room was clean, bright and uncluttered. The table settings had appropriate cutlery, napkins and crockery. The servery kitchens contained heated food trolleys, refrigeration and stainless steel fittings throughout. Food was delivered fully cooked in heated trolleys from St. Columbanus. Catering staff checked, recorded and monitored food temperatures and the temperature of the refrigerator. The cleaning schedule was also recorded and monitored. All refuse was separated and disposed outside the unit.

All staff in the kitchen area were observed wearing protective clothing. There was a separate sink for catering staff handwashing and there were changing facilities on the unit.
Environmental Health Officer report, dated 2013, was made available to the inspection team.

Compliance Rating:

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

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: There was a detailed policy in place outlining the roles and responsibilities of the approved centre and the residents. The policy also included an audit tool template.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: Storage areas within the unit were monitored by the nursing staff.

Evidence of Implementation: No resident was in their night clothes during the two day inspection. Clothing was labelled and placed in individual wardrobes in residents' rooms or in individualised boxes in a storage room. There was also another separate storage room for 'good' clothes. Residents would wear these when attending appointments outside the approved centre. There was access to a hardship fund for residents who needed urgent new clothing. Each resident had a locker and wardrobe in which to store their clothing beside their beds. Laundry facilities are available within the unit and also an outside agency.

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: A detailed policy was in place outlining roles, responsibilities and procedures for admission, money management and in the event of theft.

Training: Assistant Directors of Nursing, Principal Social Worker, Area Administrator and the Clinical Nurse Managers were responsible for the policy being adhered to by staff.

Monitoring of Compliance: The policy outlined six monthly audits but no evidence of same was observed.

Evidence of Implementation: A resident's property was itemised on a checklist on admission and stored in a property book on each wing. Resident's access to personal property and the safe guarding of their personal possessions were assessed with regard to the best interest of the resident. All residents on the days of inspection had access to their property in their wardrobes and bedside lockers. The wardrobes had no facility to lock but residents could ask staff to lock individual rooms if desired. The storage rooms were locked but residents had access if they wished through the nursing staff.
There was a secure safe for residents' valuables and access to resident monies was overseen by two staff and signed.

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: Detailed policy was in place outlining the roles, responsibilities and procedure for recreational activities. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: No formal monitoring of recreational activities was in place. However, feedback from residents was taken.

Evidence of Implementation: Information was provided to residents on the range of activities for residents. Residents were encouraged to attend groups and day activities by the staff. There was a range of activities available from groups held within the unit
The recreational room was a shared space between the West and East Wings. It had a large TV, books and games. There was also two small sitting rooms on both wings which doubled up as visitor rooms. There was a number of outdoor spaces with seating which were used for gardening and relaxing.

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: Detailed policy was in place outlining the roles, responsibilities and procedure for religion. The policy included the rights of a resident to practice his or her religion within the approved centre, that religious beliefs were respected and supports put in place for residents to observe religious practices. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: Needs were identified on transfer to the unit.

Evidence of Implementation: Mass was celebrated on the ward every Thursday. The policy included a local list of ministers of other faiths but there was no requirement at the time of inspection. The Health Service Intercultural Guide was in use in the approved centre. This guide helps services respond to the needs of diverse religious communities and cultures in healthcare settings.

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 detailed policy in place in the unit which included roles, responsibilities, visiting hours, safety for visitors and arrangements for children visiting. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: There was no documented monitoring of the processes of residents' visits.

Evidence of Implementation: Visiting times were displayed on both wings and residents were aware of this. The times were reasonable and did not interfere with residents' routines especially around meal times. Any children visiting the unit were to be supervised by appropriate adults at all times. Visiting times could be flexible to suit individual needs of the resident. There was no current visitor's room but residents and their visitors had access to a small sitting room for the duration of the visit on both wings.

Visitors were welcome outside of meal times and were to report to the nursing station before entering a resident's bedroom or bringing snacks into the hospital due to possible choking risks as per the policy.

Compliance Rating:

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

3.12 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: Detailed policy was in place outlining the roles, responsibilities and procedure for communication within the approved centre. The policy stated its procedures for mail, electronic devices and mobile phone use and the accepted times of use between 0900h – 2200h. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: Monitoring was completed through team meetings where risk assessments were completed for some residents.

Evidence of Implementation: Residents had access to a ward phone which was cordless to allow them privacy. This could be accessed through a staff nurse. Some residents had their own mobile phones which they took responsibility for. There was no computer with internet access on the ward but residents could use the local library in the community for access if they wished. Staff facilitated the purchasing of stamps and posting of letters.

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: Detailed policy was in place outlining the roles, responsibilities and procedure for searches within the approved centre. The policy also included procedures for searches with and without consent, the finding of illicit substances and an audit tool template.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. Staff demonstrated an awareness to the process and the need for consent whilst carrying out searches.

Monitoring of Compliance: There was no monitoring of the search process as there had not been any searches carried out since the last inspection.

Evidence of Implementation: The service was only inspected against processes, training and monitoring as no searches had been carried out on the unit since the last inspection.

Compliance Rating:

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

3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: Detailed policy was in place outlining the roles, responsibilities and procedure for care of the dying within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff demonstrated an awareness of the process.

Monitoring of Compliance: Deaths were notified to the Mental Health Commission.

Evidence of Implementation: There was no single room on the West Wing to accommodate privacy but there was a small sitting room which could be made available to family. The East Wing had single rooms and residents could be reconfigured, if necessary, to accommodate another resident.
The death of one resident of the approved centre had occurred since January 2015. The death occurred at the approved centre. The MHC were notified within the required timeframe.

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: Detailed policy was in place outlining the roles, responsibilities and procedure for individual care plans within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff, when starting on new teams, attended the weekly team meeting and were orientated to the unit's documentation.

Monitoring of Compliance: Individual care plans were reviewed by the multidisciplinary team every six months.

Evidence of Implementation: Fifty per cent of clinical files in the approved centre were inspected and there was evidence that all residents had an individual care plan (ICP). The initial care plan was completed on admission by the admitting doctor. The ICPs included identification of a resident's needs, goals, interventions and person responsible. There was evidence that the resident had the opportunity to contribute to their care plan and this was documented in the ICP documentation by the key worker. Attendance at a full ICP review meeting was held every six months and this was documented. There was evidence that all disciplines, including occupational therapy, social work and psychology, contributed to the review of the ICP. Reviews were also carried out every three months by the team. Residents were encouraged to participate in the ICP review and family involvement was sought. Families were invited to the six month review meeting by letter. Residents had signed their ICPs.
On each wing there was a 'medical review checklist' that listed all dates for residents' risk review, prescription review, full physical review and ICP review.

Compliance Rating:

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

3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: Detailed policy was in place outlining the roles, responsibilities and procedure for individual care plans within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy. The appendix of the policy included information booklet about the unit, procedures for community outings, group programme referral form and occupational therapy kitchen safety.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff demonstrated an awareness of the process and had training from their respective professional courses.

Monitoring of Compliance: Audits on therapeutic activities were not conducted.

Evidence of Implementation: All residents were assessed by the team for suitability to groups and therapy and appropriate referrals sent. There was evidence of residents accessing speech and language therapy, occupational therapy, psychology and social work. Information was available to residents and verbal reminders were given by staff to residents for groups, training and community outings.
An interest checklist completed by the occupational therapist with the residents was used to match residents' interests and hobbies, where possible, to activities and groups. The clinical files had weekly attendance records within each resident's file. Most groups facilitated on the ward were held in the shared dining/sitting/therapy room. Groups were facilitated by occupational therapists, activity instructors and mental health care assistant. Groups included art, bingo, aerobics, social outings, newspaper reading and discussion and gardening.
In addition, residents could attend Lime Grove, an activation centre located near the O' Connor Unit and this was documented in their care plans.

Compliance Rating:

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

3.17 Regulation 17: Children's Education

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

Inspection Findings

It was the policy of the approved centre of Kerry Mental Health Services that Children were not admitted to the O' Connor Unit, Killarney.

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: Detailed policy was in place outlining the roles, responsibilities and procedure for transfers within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff demonstrated an awareness of the process.

Monitoring of Compliance: There was no documented monitoring of the processes of transferring residents.

Evidence of Implementation: Transfers were assessed by the consultant, nurse and general practitioner.
The processes for transferring were clearly outlined in the policy. The multi-disciplinary team and key worker were involved with liaising with the other approved centre and a transfer was usually planned for and completed on a weekday.
Nursing staff accompany residents on transfers and ensure the safety and confidentiality of the resident until acceptance of the resident has occurred in the other 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		

3.19 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: Detailed policy was in place outlining the roles, responsibilities and procedure on general health within the approved centre. The policy also included access to recommended national screening programmes and responding to medical emergencies.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All medical and nursing staff had been trained in the management of general health processes.

Monitoring of Compliance: There was no formal monitoring of the processes. Regular weekly checks were maintained on all emergency equipment within the centre and these were documented.

Evidence of Implementation:
A GP from a local medical practice visited the unit daily on week days. The unit had access to the Doctor on Call in the evenings and at weekends.
The residents' needs were assessed and addressed during their transfer to the O' Connor Unit.
There was evidence of residents accessing dietetic reviews and bowel and breast screenings.
Staff had access to an Automatic Emergency Defibrillator, which was located in the nurses' station on the East Wing. Oxygen was available on both wings.
Residents' health was reviewed using a 'physical review' document. All reviews used the template but some of the reviews were incomplete. There was no private space for residents to have their health needs assessed. All clinical charts showed health reviews every six months but lacked detail.

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				

3.19 Regulation 19: General Health

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	*9th 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 Consultant to meet with GPs who provide physical reviews to feedback need for full completion of Medical examination on the pro forma. Post-Holder(s): Consultant & Specialist Reg	Residents' health was reviewed using a 'physical review' document. All reviews used the template but some of the reviews were incomplete. All clinical charts showed health reviews every six months but lacked detail.	Re audit by Speciaist Registrar	Achievable and feasible	3 months
2. Preventative: 3 monthly audits will be carried out Post –Holder(s): Senior Registrar	There was no formal monitoring of the processes.	Audit	Achievable	January 2016 & ongoing thereafter

3. Corrective: This is addressed in the new building Deer Lodge	There was no private space for residents to have their health needs assessed.		Yes	Q1 2016

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: Detailed policy was in place outlining the roles, responsibilities and procedure on the provision of information to residents within the approved centre. The policy included visiting arrangements, the content of the information given, the monitoring of the provision of information to residents and their families and the process for giving information about medication. The advocacy arrangements and interpretation services were not in the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: No formal audits or analysis were evidenced.

Evidence of Implementation: Residents transferred to the unit were given an information booklet, in understandable form, which had housekeeping arrangements, the complaints procedure, residents' rights and the details of their multidisciplinary team.
On both wings there were two folders which had information on diagnosis and medication for residents. Residents could also speak to staff with questions they had about their admission, medication and treatment.
The notice boards within the unit displayed information on advocacy and voluntary agencies.

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: Detailed policy was in place outlining the roles, responsibilities and procedure on privacy within the approved centre. The policy also included an audit template.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff demonstrated an awareness of the process.

Monitoring of Compliance: There was no evidence of monitoring in the approved centre.

Evidence of Implementation: Throughout the two day inspection, residents were referred to by name by the staff. Residents were in their own clothing, had a screen around their bed, single rooms had observation panels and they could use the toilet and shower facilities independently.
Bedroom windows had net curtains. Outdoor spaces were not overlooked.
Residents had access to a portable phone and/or their own phones for privacy with making/receiving calls.
All clinical records were confidential and stored in the nursing office.

Compliance Rating:

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

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

Inspection Findings

Processes: Detailed policy was in place outlining the roles, responsibilities and procedures on premises within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: Staff were not formally trained but staff were aware of the method of reporting faults and repairs.

Monitoring of Compliance: There was a schedule of cleaning for the unit that was rotated amongst the household staff.

Evidence of Implementation: The building was built in the 1970s and was dated in appearance. On inspection, building rubble and discarded mattresses were observed off the West Wing. A resident was observed walking around in this. The inspection team asked the managers to cordon off the area and remove waste as soon as possible.
The unit had access to a number of outdoor spaces. The outdoor spaces were not overlooked and allowed the residents to have privacy but they were bleak and uninviting. The overall environment of the unit created limited opportunity for engagement in meaningful activities with dated furniture, poor ventilation, outdated bathrooms with poor lighting and shared bedroom spaces.
The unit was wheelchair accessible and had a number of assistive devices on both wings to accommodate residents and their needs. Notice boards on both wings provided information on groups/outings.
Maintenance was completed through a central reporting system and done on a basis that there was a new unit due to open in 2016. The unit was observed to be in disrepair with

peeling paint, dated furniture and soft furnishings. Heat was centrally controlled and the unit had a generator.

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	*9th 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.Progress move to new premise- Deer Lodge Corrective Post-Holder(s): MHMT	The building was built in the 1970s and was dated in appearance. The unit had access to a number of outdoor spaces. The outdoor spaces were not overlooked and allowed the residents to have privacy but they were bleak and uninviting. The overall environment of the unit created limited opportunity for engagement in meaningful activities with dated furniture, poor ventilation, outdated bathrooms		Feasible and achievable Building is complete and is currently being commissioned.	Q1 2016

	with poor lighting and shared bedroom spaces. . The unit was observed to be in disrepair with peeling paint, dated furniture and soft furnishings.			
2. Estates to arrange for the removal of rubble etc. Corrective Post-Holder(s): Estates	On inspection, building rubble and discarded mattresses were observed off the West Wing. A resident was observed walking around in this. The inspection team asked the managers to cordon off the area and remove waste as soon as possible.		Achievable	Completed

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 with regard to ordering, prescribing, storing and administration of medicines. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: Management of medication was only done by trained medical and nursing staff, who had received training in medication as part of their professional training.

Monitoring of Compliance: There was no evidence of monitoring in the approved centre.

Evidence of Implementation: Staff were aware of relevant legislation and codes of professional conduct with regard to medication. There was a procedure for reporting medication errors and adverse effects.

Medication information was available to residents on both wings. Medication for the resident was reviewed at least every six months or as required. All leave medications were discussed with the resident and supplied in blister packs. The GP who visited the unit on weekdays completed the prescriptions. Medications delivered from the pharmacy were checked on receipt. Expiry dates were checked prior to administration.

Medication was stored in a locked cupboard in the locked clinical rooms on both wings. Controlled drugs were maintained by two staff and the quantities were balanced with the Controlled Drug Book entries. Medication was stored in dry clean presses and fridges in the clinical rooms. Fridges within the clinical room were used appropriately and there was evidence of a temperature log. A stock rotation system was in place.

The prescription and administration of medication was documented and each resident had a unique medication administration record. However, there were two different medication records being used in the unit. The old medication record contained no space for Medical Council Registration Numbers (MCRN). There were two MCRN missing from two medication records.

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	*9th 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.Remove old medication charts Corrective Post-Holder(s): Consultant & CNM 2	There were two different medication records being used in the unit. The old medication record contained no space for Medical Council Registration Numbers (MCRN).	Monthly Audit of all patient charts to ensure that correct prescription chart is in place	Feasible	30th November 2015 & ongoing
2.Advise all medical staff re need to include MCRN at meeting with GPs and Practice manager Preventative & Corrective Post-Holder(s): Consultant , Specialist Registrar	There were two MCRN missing from two medication records.	Monthly Audit	Feasible	Monthly commenced Nov'15

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: Detailed safety statements were in place - one for each wing. The statements outlined the roles, responsibilities and procedures on health and safety within the approved centre. There was also an overarching policy for the Kerry Mental Health Services. The approved centre had a committee whose responsibility was to oversee: risk and patient safety; health and safety; and the risk register. The centre had no emergency plan procedures or Environment Health Officer's report available on the days of inspection.

Training: Staff were appropriately trained in relation to health and safety. The training record for staff training showed that training was provided in manual handling, handwashing, infection control, first aid, fire safety, the management of sharps, and the prevention of slips, trips and falls. The staff induction programme included the emergency procedures and use of equipment. Staff were trained in reporting incidents. Staff training in the prevention and management of violence and aggression was part of induction with regular training updates.

Monitoring of Compliance: There were scheduled audits of infection control measures within the approved centre, regular fire safety awareness and drills. Maintenance completed reviews of works that needed to be done to maintain the building. Regular audits of the cleaning for the kitchen and dining area were inspected on inspection.

Evidence of Implementation: Staff were aware of their role in safety and there was a staff safety representative within the unit.
Exits, emergency lighting, smoke detectors, fire extinguishers and fire procedures were clearly displayed in the unit. The unit vehicle was maintained by the area administrator.
The unit had a falls risk initiative in place.
The unit had many mounted hand gels available and hand washing facilities for staff. Kitchen and dining staff used protective clothing when carrying out their duties and had access to changing facilities.
Sharp bins were used appropriately and this was observed by the inspectors.

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 Close 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

CCTV was not used within the approved centre. 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

3.26 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: Detailed policy was in place outlining the roles, responsibilities and procedures on the recruitment, staffing levels, staff supervision and training, healthy work environment and resources for staff within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: The Executive Clinical Director, Area Director of Nursing, Heads of Discipline, Area Administrator and the Clinical Nurse Managers were responsible for the policy being adhered to by staff.

Monitoring of Compliance: No formal audits or analysis were evidenced.

Evidence of Implementation: The approved centre had an organisational chart with a governance structure in place.
On both days of the inspection, there was an identified staff member in charge on both wings. The staffing rosters were inspected.
The files of two members of staff were inspected and showed evidence of job description, qualifications, Garda vetting and up-to-date registration with the relevant Regulatory bodies. There was no documentation on staff performance.

New staff members were supervised and supported by the clinical nurse manager during an induction process. The training record of nursing staff showed evidence of regular training in several areas of practice. Annual training plans were developed for the service and further continued professional development was supported. No agency staff were used in the unit. All staff were aware of the Mental Health Act 2001 and demonstrated this to the inspectors.

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 a detailed policy in place which outlined the roles and responsibilities. It provided guidance on accessing records, retention of records, destruction of records and good practice guidelines for record keeping. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: Staff were not formally trained but all Clinical Nurse Managers orientate staff to the policy.

Monitoring of Compliance: Evidence of audit was not available. There were no incident records logged relating to matters pertaining to the maintenance of records.

Evidence of Implementation: Clinical records were observed to be in good order and had a table of contents at the start of each record. All residents had their own record with a unique Medical Record Number (MRN) which were stored in the ward office. Only staff had access to the records. There was a formal process in place for residents wishing to have access to their records.
The policy outlined the HSE retention for clinical records.
Health and safety reports, Environmental Health Officer report and fire inspection reports were available on the days 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		

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

Processes: There was a process in place to record the elements specified in the Schedule 1 to the Regulations.

Training: The relevant staff were aware of the processes involved.

Monitoring of Compliance: The data gathered incorporated the requirements of Schedule 1 to the Regulations and contained up-to-date information. There was no evidence of audit.

Evidence of Implementation: The Register was retained both electronically and in hard copy and was inspected by the inspector. The Register contained all the data required by 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: Detailed policy was in place outlining the governance, roles and responsibilities on operating policies and procedures within the approved centre. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: Relevant staff were trained and aware of the requirements under the regulation. There was no documentation in relation to training for this.

Monitoring of Compliance: All policies and procedures were reviewed within the last three years.

Evidence of Implementation: There was a clear governance structure in place for encouraging staff input into formulating policies and procedures for the approved centre and in approving the policies and procedures. Policies are shared with staff through their line managers.
All policies reviewed were reviewed within the last three years. Policies were stored electronically and there was a hard copy version for the unit. Old policies were removed from the information system as per the *HSE computer system policy.*

Compliance Rating:

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

3.30 Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

Processes: There was a detailed policy in place for this regulation outlining the roles and responsibilities for the O' Connor Unit. The policy also identified the resources, including staff to assist the patient at tribunals. It did not address the issue of provision of information to the patient about tribunals in the policy or training for staff only that staff read and adhered to the policy.

Training: The Clinical Nurse Manager was responsible for ensuring the policy was disseminated to all staff. Training on tribunals is provided by the HSE to designated Mental Health Act (MHA) administrators.

Monitoring of Compliance: The policy and procedure were monitored by the designated MHA administrator and any improvements deemed necessary were implemented.

Evidence of Implementation: Tribunals were held in a room on the East Wing. All necessary facilities, including the availability of staff to accompany a patient when necessary, were made available. There was information available for patients on tribunals which could be tailored.

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 detailed policy in place and in date. The service also used the HSE Policy- *Your Service, Your Say.*

Training: Induction training for staff included the handling of complaints.

Monitoring of Compliance: The complaints officer recorded and analysed complaints and this was circulated to staff. There was no record of an annual audit of complaints.

Evidence of Implementation: There were a number of notices clearly outlining the complaints procedure and *Your Service, Your Say* brochures around the O' Connor Unit. The complaints procedure was included in the information booklet also. Complaints were recorded in a complaints log, which included the outcome of the complaint. There was a specified timeline with regard to processing complaints. Complaints viewed in the log were dealt with quickly. Records of complaints were maintained in a secure location.

Clinical Nurse Managers dealt with complaints but there was no nominated person displayed or within the information booklet given to residents as per regulation 31(4).

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			

3.31 Regulation 31: Complaints Procedure

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	*9th 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. While awaiting the move to the new premises and a new information booklet which will contain the necessary information, details of the Complaints procedure including the nominated person will be given to each resident and it will also be attached to each of the Information Booklets for the O'Connor Unit. Corrective Post-Holder(s): Area Administrator &CNM 2	There was no nominated person (for complaints) displayed or within the information booklet given to residents as per regulation 31(4).	Each resident will be asked to acknowledge receipt of the complaints procedure by signing a log book	Feasible	30th November 2015.
2.Corrective: Referred to the audit committee Post-Holder(s): Audit Committee	There is no record of an annual audit of Complaints	Audit	Feasible	Q1 2016

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 detailed policy in place which outlined the roles, responsibilities and procedures for monitoring risk within the approved centre. The risk management policy was in conjunction with two other policies in use in the approved centre – special observation policy and the management of violence policy. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: Relevant staff were trained on risk management within the approved centre. Organisational risk training was provided to senior staff. Training records were maintained within the centre.

Monitoring of Compliance: Risk is monitored by the multi-disciplinary team for residents and is reviewed over the admission. There is a monthly review group that review incidents, actions and analysis of trends for the whole unit.

Evidence of Implementation: Seventeen individual clinical files were inspected. Risk assessments had been completed at the time of transfer to the unit. The multi-disciplinary team discussed and reviewed risk at each team review and documented in the ICPs. The records showed an individualised approach to risk management.
There was clear governance structures in place within the unit to review risk. The risk register was inspected on inspection and incidents were recorded on this.

Notifications to the Mental Health Commission were outstanding for the January – June 2015. The service had no emergency plan for the O' Connor Unit.

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				

3.32 Regulation 32: Risk Management Procedure

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	*9th 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.An Emergency plan for the O'Connor Unit will be drawn up and included as an amendment to the Risk Management Policy. Corrective Post-Holder(s): Nurse Practice Development Co-Ordinator	The service had no emergency plan for the O'Connor Unit.	Form part of the safety statement for the new premises Deer Lodge	Feasible	10th December 2015- next meeting of the Risk /Incident sub group
2.The January to June 2015 notifications of incidents will be forwarded to the MHC. It is noted that the system of inputting incidents changed during the year from STARS web to NIMS hence the delay in issuing reports. Staff will receive further training and this should not cause a delay in the future. Corrective Post-Holder(s): Mental Health Act Administrator	Notifications to the MHC were outstanding Jan to June 2015.		Achievable	13th November 2015 & ongoing

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

Processes: There was a process in place to ensure that the approved centre was appropriately covered by insurance.

Training: The relevant staff were aware of the necessity to ensure that the approved centre was insured.

Monitoring of Compliance: The requirements for insurance was reviewed annually and was processed through the HSE Corporate offices in Naas.

Evidence of Implementation: The approved centre was insured under the State Claims Agency (SCA) and a Confirmation Statement was available to inspectors. As the State indemnity was enshrined in legislation, the Confirmation Statement issued by the SCA operated in lieu of a certificate of insurance.

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

Processes: There was a process in place to ensure the Certificate of Registration was displayed.

Training: The relevant staff were aware of the necessity to display the certificate.

Monitoring of Compliance: The Certificate was up to date.

Evidence of Implementation: The Certificate of Registration was displayed in a prominent place in the approved centre inside the main door on the East Wing. The certificate detailed the name of the approved centre and the date of registration.

Compliance Rating:

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

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Inspection Findings

ECT was not administered in the approved centre and this rule was not applicable.

Compliance Rating:

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

4.2 Section 69: The Use of Seclusion

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

Inspection Findings

Seclusion was not in use in the approved centre and this rule was not applicable. There was no policy to reflect this.

Compliance Rating:

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

4.3 Section 69: The Use of Mechanical Restraint

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

Inspection Findings

Processes: There was a detailed policy which was in date for the unit which included roles, responsibilities and procedures.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers.

Monitoring of Compliance: Policy is to be reviewed yearly by the approved centre.

Evidence of Implementation: A register was available for the inspectors. There was evidence of ongoing reviews and assessment. On the inspection days there was one resident who was using a lap belt. There was evidence of ongoing review for this resident and it was clearly documented in the clinical files and care plan. Staff demonstrated awareness of the policy and procedures.

Compliance Rating:

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

5.1 Part 4: Consent to Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was no policy in place for the provision of consent to treatment by detained patients but staff were aware of the process involved as outlined in Section 60 of the Mental Health Act 2001.

Training: Staff were aware of the necessity to obtain consent for administering medication in the approved centre.

Monitoring of Compliance: There was no evidence that audits had been carried out and no incident reports had been completed on non-compliance.

Evidence of Implementation: The unit used the HSE 'consent to medication form' which clearly outlined the medication being administered, consultant and patient names and signatures.
On inspection medication was given in accordance with Section 60.
One chart was reviewed during the inspection of an involuntary patient. The required consent and information required was documented. All documents were made 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		

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 detailed policy that was in date for the unit which included roles, responsibilities and procedures. The policy also included an audit tool and staff signature sheet to say they understood and agreed to the policy.

Training: All staff are responsible for reading and adhering to the policy which they received from their line managers. All staff receive Prevention of and Management of Violence.

Monitoring of Compliance: The policy was reviewed within the last year.

Evidence of Implementation: Physical restraint was not used in the approved centre since 2011 and therefore this rule was not applicable.

Compliance Rating:

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

6.2 Admission of Children

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

Inspection Findings

It was the policy of the Approved Centre of Kerry Mental Health Services that Children were not admitted to the O' Connor Unit.

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: A comprehensive incident reporting policy was in place. The policy outlined the roles and responsibilities of the approved centre. It also clarified the reporting process, risk evaluation, incident forms, corrective actions, reviews and future actions.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. Staff were aware of the processes involved in reporting of deaths and incidents.

Monitoring of Compliance: Incidents were monitored monthly by the senior management team.

Evidence of Implementation:
The approved centre had a Mental Health Administrator who took responsibility for notifying the Mental Health Commission and for compiling reports for the senior management meeting.

A record of incidents was maintained in the approved centre and the Incident Report forms for the year prior to the inspection were available. The service used a localised incident report form which was suitable for inclusion in the national incident reporting system.

At the time of inspection, the Mental Health Commission had not received the summary of incident reports from January – June 2015.

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			

6.3 Notification of Deaths and Incident Reporting				
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	*9th 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.Summary of incident reports were forwarded to MHC . Corrective Post-Holder(s): Mental Health Act Administrator	At the time of inspection, the Mental Health Commission had not received the summary of incident reports from January – June 2015.		Achievable	Complete

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

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

Inspection Findings

Processes: Detailed guidelines were in place outlining the governance, roles and responsibilities, capacity and advocacy services on mental health services for people with intellectual disabilities within the approved centre. The guidelines did not contain training requirements or child protection information.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff demonstrated an awareness of the process. Training to these guidelines was due to commence in 2016.

Monitoring of Compliance: No formal audits or analysis were evidenced.

Evidence of Implementation: During inspection, clinical files of the relevant residents indicated that a needs assessment focused on issues but was not specific to intellectual disabilities. This assessment was documented in the care plan. Capacity was not formally assessed. Decision making was supported by individual assessment on an ongoing basis. Treatment was provided on a least restrictive basis and a functional approach was taken to assessing the residents' capacity to make choices. Family and advocacy support was available to the residents if required.
Assessment of specific intellectual disability needs was not evident and staff had no training.

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			

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

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	*9th 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.Arrange training for staff Corrective Post-Holder(s): NPDC	Staff had no training	Training log	Feasible	Ongoing
2. Modify care plans to address specific needs of residents with an intellectual disability. Corrective Post-Holder(s): Consultant	a needs assessment focused on issues but was not specific to intellectual disabilities. This assessment was documented in the care plan. Capacity was not formally assessed.	Audit of care plans	Achievable	31st January 2016
3. Ongoing assessment/audit of policy and the MHC Code of Practice will be undertaken. Preventative Post-Holder(s): CNM 2	No formal audits or analysis were evidenced.	Self assessment reports	Feasible	Ongoing.

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

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

Inspection Findings

ECT was not administered in the approved centre and this rule was not applicable.

Compliance Rating:

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

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: Detailed policies were in place outlining the roles, responsibilities and procedures for admissions, transfers and discharges within the approved centre. The policy also included a staff signature sheet to say they understood and agreed to the policy.

Training: All staff were responsible for reading and adhering to the policy which they received from their line managers. All staff demonstrated an awareness of the process.

Monitoring of Compliance: There was no evidence of audits or analysis for the processes of admission, transfer and discharge.

Evidence of Implementation:

Admissions: There was one condition attached to the registration to the O'Connor Unit – no direct admissions. All admissions were planned transfers from Kerry General Hospital in Tralee. On transfer all residents were reviewed by the multi-disciplinary team and a physical assessment was completed. The resident was allocated a key worker. Family were involved in the care planning if the resident wished. Clinical files were reviewed on inspection and contained relevant data from the transferring hospital in Tralee.

Transfers: Transfers were assessed by the consultant, nurse and general practitioner.
The processes for transferring were clearly outlined in the policy. The multi-disciplinary team and key worker were involved with liaising with the other approved centre and a transfer was usually planned for and completed on a weekday.
Nursing staff accompany residents on transfers and ensure the safety and confidentiality of the resident until acceptance of the resident has occurred in the other approved centre.

Discharges: There had been no discharges - only transfers to other approved centres or nursing homes in recent months.

Compliance Rating:

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