2017 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, University Hospital Galway

ID Number: AC0023

Approved Centre Type:
- Acute Adult Mental Health Care
- Psychiatry of Later Life
- Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
1 March 2017

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager
CHO2 – Mental Health Services

Inspection Team:
Barbara Morrissey, Lead Inspector
Siobhán Dinan
Mary Connellan
Carol Brennan-Forsyth

Inspection Date:
23 – 26 May 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
14 – 16 June 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
9 November 2017

COMPLIANCE RATINGS 2017

- **REGULATIONS**
  - Compliant: 24
  - Non-compliant: 1
  - Not applicable: 6

- **RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001**
  - Compliant: 3
  - Not applicable: 1

- **CODES OF PRACTICE**
  - Compliant: 3
  - Non-compliant: 1
  - Not applicable: 2
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

Chart 2 – Comparison of overall risk ratings 2015 – 2017
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Appendix 1: Corrective and Preventative Action Plan Template – Le Brun House and Whitethorn House, Vergemount Mental Health Facility ........................................................................... Error! Bookmark not defined.
1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

Inspector of Mental Health Services

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

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

Safety in the approved centre

There was a written policy in place and an associated safety statement in relation to health and safety as well as a risk management policy. Quality and safety walkabouts took place on a regular basis with the maintenance department and with unit staff. There was safe processes in place for the ordering, prescription, storage and administering medication. Resident identifiers were checked before staff administered medications, carried out medical investigations, and provided other health care services. The catering company completed food safety audits. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas, and associated catering and food safety equipment were appropriately cleaned.

Not all health care professionals were up to date with required training in fire safety, Basic Life Support, management of violence and aggression, and the Mental Health Act 2001. Physical restraint was carried out in a safe manner.

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

Appropriate care and treatment of residents

Four residents were in the approved centre for a period of over six months and their six-monthly physical examinations were documented. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. Each resident had an individual care plan (ICP). All ICPs were a composite set of documentation detailing appropriate goals, treatment, care, interventions, reviews, and resources required. The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, and met the needs of the residents. Residents were given an individual therapeutic programme adapted to their own needs and aligned with their care plan, goals, and interventions. Therapeutic services and programmes were provided in a separate dedicated room or in the occupational therapy department. Due to limited space in station C, the high observation unit, groups had to be facilitated in the dining area, however there was an appropriate quiet room where one to
one sessions could be facilitated. Not all clinical files were in good order. The approved centre was compliant with the rules on electro-convulsive therapy and seclusion.

**Respect for residents’ privacy and dignity**

Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions. Each resident had a locker and a small wardrobe beside their beds and a larger locked locker in the resident property room. Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs. Searches were implemented with due regard to each resident’s dignity, privacy and gender. Two CCTV cameras positioned in the internal garden areas of the approved centre were found to be recording residents’ images. The high observation beds near the nurses’ offices in Station A and B opened out on to the unit. There were no walls or partition and this did not afford privacy for the residents accommodated in these areas, as it was not feasible to have privacy curtains drawn at all times.

**Responsiveness to residents’ needs**

Residents were provided with menus offering a variety of wholesome and nutritious food choices and meals were attractively presented. Residents could use mail and telephone. There was no internet available for residents in the approved centre. There was no dedicated visiting room in the approved centre, however a room was provided when required and this room was made available for children visiting. Visiting areas such as the quiet room and garden, were also available, where residents could meet visitors in private. Residents’ rights to practice religion were facilitated. There was a chapel in the main hospital of the approved centre and multi-faith chaplains were available. A separate quiet room was available to residents for quiet reflection and prayer.

Residents were provided with an information handbook at admission, and it included all necessary information on housekeeping arrangements. Information was available on medication and diagnosis. Ligature points were not minimised despite a ligature audit having taken place. There was no programme of general maintenance or decorative maintenance. Heating was centrally controlled and could only be turned on or off. At the time of the inspection, the weather was extremely warm and radiators remained on. The approved centre was not clean, hygienic, and free from offensive odours. The inspection team requested a deep clean of the bathrooms on the first day of the inspection. The approved centre did not provide suitable furnishings to support resident independence and comfort. There was a well-advertised complaints procedure in place.

**AREAS REFERRED TO**


**AREAS REFERRED TO**

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

The approved centre was a part of the HSE Community Healthcare Organisation (CHO) 2 area. Governance of the approved centre was managed by the executive management team. Overarching clinical governance mental health teams met monthly. This was a forum for the different staff disciplines providing input to the approved centre to meet together to discuss specific governance matters. Mutual support meetings took place on the unit between residents and staff to address any items of concern and to improve quality and services. The operating policies and procedures were developed with input from nursing, clinical, and business staff and in consultation with relevant stakeholders, including service users. Operating policies and procedures were communicated to all relevant staff and were reviewed within three years.

The unit had 15 consultant-led teams that could admit to the approved centre. The CHO 2 area had a quality and safety risk advisor who sat on the clinical governance mental health team and provided training once a month on risk management and incident reporting. All heads of disciplines met monthly. There was service user involvement on senior management team.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Quality and safety walkabouts through the unit with the maintenance department and with unit staff.

2. Service user involvement on senior management team.

3. Medication alert aprons now worn during the administration of medication.

4. Mutual support meetings on unit. (These are quality improvement meetings between staff and residents).

5. A new 50 bedded unit has now been built in the grounds of the University Hospital Galway. This will be the new approved centre.

6. Whiteboards on display on each station to assist with the provision of information to residents.
4.1 Description of approved centre

The Department of Psychiatry, University Hospital Galway, was a registered 45-bed unit, located on the ground floor of the university hospital, Newcastle Rd, Co. Galway. The unit was accessed through a side door at the back of the hospital, or via St. Anthony’s ward in the general hospital, as the unit was connected to the main hospital by a link corridor. The unit was not well signposted within the main hospital and there was no reception or waiting area at the entrance to the approved centre. The main hospital had a shop and a café. The unit was laid out in three areas, station A, which was the male ward; station B, the female ward; and station C, the high observation unit. Station C was a six-bed area, and on the first day of the inspection there were six patients accommodated in this area. The approved centre was locked and access was via swipe card or by staff releasing the door mechanism.

A gym facility was available in the approved centre, but as there was not an appropriately qualified instructor available, this was not in use at the time of the inspection. A charter of patient rights was displayed in the approved centre. Fifteen consultant-led teams admitted residents to the approved centre, including two psychiatry of later life teams, one rehabilitation and recovery team and one mental health intellectual disability team. The approved centre was the main regional centre for electro-convulsive therapy with a dedicated consultant and nursing staff. The approved centre in Roscommon University Hospital also admits to the centre if it requires further beds. The approved centre operated mostly on full capacity. It was noted that when residents went on leave from the unit, then these beds had been used as admission beds. The high observation areas in both station A and B, open out on to the unit. There was no walls or partition for this area and this was of concern in terms of resident privacy, as it was not feasible for privacy curtains to be drawn at all times. The general maintenance of the premises was not of a high standard.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>45</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>44</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>Number of Wards of Court</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>4</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.
**Condition 1:** To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 2:** The approved centre shall submit a plan to the Mental Health Commission for the closure of the approved centre, including the transfer or discharge of all current residents. The approved centre shall provide updates on the closure plan in a form and frequency prescribed by the Commission. The updates shall include ongoing maintenance to be undertaken on the approved centre premises up until all residents have been transferred or discharged.

### 4.3 Reporting on the National Clinical Guidelines

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

### 4.4 Governance

The approved centre was a part of the HSE’s Community Healthcare Organisation 2 area. Governance of the approved centre was managed by the executive management team. Members of the team included the executive clinical director, the clinical director, the head of mental health services, the acting area director of nursing for Galway/Roscommon, the general manager, principal social worker, occupational therapy manager, and consultant psychiatrists from each sector and the approved centre’s assistant director of nursing. Overarching clinical governance mental health teams met monthly in Ballard House in Galway. This was a forum for the different staff disciplines providing input to the approved centre to meet together to discuss specific governance matters. Copies of the minutes were provided to the inspection team, which outlined an active governance process. Issues raised in the minutes included the forthcoming opening of the new approved centre and also the creation of a smoke-free campus.

Issues from the approved centre’s subcommittees such as acute unit business meetings, health and safety meetings, drugs and therapeutics and policy and procedure committees escalated issues to this monthly overarching meeting. Staff training was discussed at the health and safety meeting. Bed capacity and incidents were standing items on the agenda at the acute unit business meeting. Discussion with members of senior management confirmed a current focus on risk minimisation and on addressing various areas of non-compliance with required regulations and rules, as outlined by the Mental Health Commission, (MHC). Mutual support meetings took place on the unit between residents and staff to address any items of concern and to improve quality and services. The unit had 15 consultant-led teams that could admit to the approved centre and there appeared to be limited office space to accommodate this.
## 5.0 Compliance

### 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 14 – 16 June 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance. These are included in Appendix 1 of the report.

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

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

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

During the inspection the inspection team met with three residents. Residents were complimentary about the care received from staff and food provided in the approved centre. Residents reported that they would like if there was more tea and coffee available. One resident reported that they were not offered a copy of their care plan.
7.0 Interviews with Heads of Discipline

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

- Executive Clinical Director
- Clinical Director
- Acting Area Director of Nursing
- Business Manager
- Occupational Therapy Manager
- Principal Social Worker

The following was unable to meet the inspection team:

- Head of Psychology

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Responsibilities were allocated at management level to ensure the effective implementation of risk management. Each clinical discipline had its own governance structure with clear line management. The assistant director of nursing was located in the approved centre from Monday to Friday. Representatives from nursing, medical, social work, and occupational therapy each provided a clear overview of the governance within their respective departments. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments. Business plans had been put forward to enhance the therapeutic and the recreational programme.

The new unit will be a 50-bed unit and will include Psychiatry of Later Life. The acting area director of nursing was the chair of the steering group for the new approved centre. The CHO 2 area also had a quality and safety risk advisor who sat on the clinical governance mental health team and provided training once a month on risk management and incident reporting. There was a mentoring system in place for all new nursing staff. All heads of disciplines met monthly.
8.0 Feedback Meeting

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

- Clinical Director
- Head of Service
- Consultant Psychiatrist
- Nurse Practice Development Coordinator
- Acting Area Director of Nursing
- Clinical Nurse Manager 3 x 2
- Assistant Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker
- Mental Health Act Administrator
- Business administrator
- Electro-Convulsive Therapy Nurse
- Principal Social Worker

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. A number of clarifications were provided regarding various issues that had arisen during the course of the inspection and these are incorporated into the report.
9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
Regulation 4: Identification of Residents

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

INSPECTION FINDINGS

Processes: The approved centre had a Galway Roscommon Mental Health Services generic policy in place, dated November 2016, on the identification of residents. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: An annual audit was undertaken to ensure that there were appropriate resident identifiers on clinical files. A documented analysis had been completed to identify opportunities for improving resident identification processes.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual resident needs were detailed within the residents’ clinical files.

The approved centre used the name, date of birth, address, and medical record number of each resident as identifiers. The identifiers used were person-specific and appropriate to the residents’ communication abilities. Room number and physical location were not included on the identifiers. The identifiers within the residents’ clinical files were checked before staff administered medications, carried out medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

While the policy detailed that there was an alert sticker in place to distinguish between residents with the same or a similar name, in practice a highlighter pen was used on Medication Prescription and Administration Records to distinguish between residents with the same or a similar name. In one clinical file inspected, 12 pages of progress notes failed to use two means of identification.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 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 approved centre did not have a policy in place in relation to the provision of appropriate food and nutrition to residents.

Training and Education: There was no policy in place for staff to read, and articulate.

Monitoring: A systematic and regular review of menu plans was conducted by the approved centre’s contracted catering company, Aramark Catering. The aim of the review was to ensure that residents were provided with wholesome and nutritious food suitable to their needs. A documented analysis was completed to improve the food and nutrition processes.

Evidence of Implementation: Food was properly prepared in the main hospital kitchen. The approved centre’s menus had been reviewed and approved by both the hospital dietician and the dietician with the catering company to ensure nutritional adequacy in accordance with the resident’s dietary needs. Residents were provided with menus offering a variety of wholesome and nutritious food choices.

Hot meals were served daily, at breakfast, lunch, and teatime. Meals were attractively presented. Both hot and cold drinks were offered regularly. Residents had adequate supplies of safe and fresh drinking water through easily accessible water fountains located throughout the approved centre.

The needs of residents identified as having special nutritional requirements were reviewed regularly. An evidence-based nutritional assessment tool was used. Nutritional and dietary needs were assessed, where necessary, and addressed and documented in the residents’ individual care plans. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
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 approved centre had a policy in place on food safety, dated November 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP), and the training was documented. Staff had up-to-date certificates in food safety training.

Monitoring: Food temperatures were recorded in line with food safety recommendations, and a log sheet was maintained and monitored. Food safety audits were completed by the catering company. A documented analysis was not completed by the approved centre.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery to suit the needs of residents in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 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: The approved centre had a written policy, dated July 2014, in relation to residents’ clothing. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to log indicate that they had read and understood the policy on residents’ clothing. Relevant staff interviewed were able to articulate the processes on residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis, and the record was kept in the linen room. A record of residents wearing night clothing during the day was kept and monitored.

Evidence of Implementation: Residents changed out of nightclothes during daytime hours unless otherwise specified in their individual care plans. Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs. There was no laundry facilities on site, but residents could avail of a launderette service if they wished.

Residents had an adequate supply of individualised clothing. All residents had storage facilities in their bedrooms. Each resident had a very small wardrobe. All residents were provided with a bedside locker. Residents were provided with emergency personal clothing that was appropriate to them and considered their preferences, dignity, bodily integrity, and religious and cultural practices.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy dated October 2016 relating to residents’ personal property and possessions. The policy included all of the requirements of the Judgement Support Framework.

**Training and Education:** Relevant staff had signed a log to indicate that they had read and understood the policy on residents’ personal property and possessions. Relevant staff interviewed were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

**Monitoring:** Personal property logs were monitored. A documented analysis was completed to identify opportunities to improve the processes for managing residents’ personal property and possessions.

**Evidence of Implementation:** Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. Small amounts of cash and valuables were held in the approved centre. Each resident had a locker and a small wardrobe beside their beds and a larger locked locker in the resident property room.

The approved centre maintained a signed property checklist detailing each resident’s personal property and possessions. The property checklist was kept separate to the resident’s individual care plan (ICP). Residents were given a copy of their property checklist. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre did not have a policy in place in relation to the provision of recreational activities.

Training and Education: There was no policy in place for staff to read and articulate.

Monitoring: There was a record of the occurrence of planned recreational activities, including a record of resident uptake. A documented analysis had not been completed to identify opportunities to improve the processes for recreational activity.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile, on weekdays and during the weekend. A weekly schedule of recreational activities was available to residents and displayed on the whiteboard on each ward. Occupational therapy and nursing staff provided a schedule of activities in the approved centre.

Residents had access to a wide range of appropriate recreational activities such as TV, books, a pool table, arts, crafts, and cookery. Opportunities were provided for indoor and outdoor exercise and physical activity. The outdoor space available for residents in the high observation unit was small. There was a spacious internal garden for residents in the two main ward areas.

Resident opinions on recreational activities were taken into account by staff on a one-to-one communication basis and through group forums, most notably the “Mutual Help Meeting”. The Mutual Help Meeting provided information for residents and gave residents an opportunity to make suggestions and requests. Attendance and participation in recreational activities was documented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
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: The approved centre had a policy in place, dated November 2016, on religion. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: The implementation of the policy to support residents’ religious practices was reviewed and documented to ensure it reflected the identified needs of the residents.

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable, with suitable facilities available to support their religious practices. There was a chapel in the main hospital of the approved centre, and mass was offered daily to residents. A separate quiet room was available to residents for quiet reflection and prayer. Multi-faith chaplains were available. Residents could access local religious services and were supported to attend, if deemed appropriate following a risk assessment. Residents were facilitated to observe or abstain from religious practice in accordance with their own wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated October 2016, in relation to visits. The policy included the requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on visits. Relevant staff interviewed could articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents’ rights to receive visitors were monitored, and reviewed on an ongoing basis. A documented analysis of the processes relating to visits had not been completed.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed at the entrance area and in each individual ward. Visiting times were also detailed in the resident information booklet.

There was no dedicated visiting room in the approved centre, however a room was provided when required and this room was made available for children visiting. Staff and residents were aware that children had to be accompanied at all times during visits. Visiting areas such as the quiet room and garden, were also available, where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk as indicated in the residents individual care plan. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring and evidence of implementation pillars.
### Regulation 12: Communication

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy, dated March 2017, and procedures in relation to communication. The policy included all of the requirements of the Judgement Support Framework.

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

**Monitoring:** Resident communication needs and restrictions on communication were monitored on an ongoing basis. A documented analysis had been undertaken to identify opportunities to improve the communication processes.

**Evidence of Implementation:** The approved centre completed individual resident risk assessments, when necessary, in relation to any risks associated with residents’ external communications; these were documented in each resident’s individual care plan. At the time of the inspection all residents were free to communicate at all times. Residents could use mail and telephone. Some residents had their own mobile phone and had internet access via these phones. There was no internet available for residents in the approved centre. If residents wished to make a call, they could use the phone at the nurses’ stations or in an office at Station B. Only the clinical director or a senior member of staff designated by the clinical director examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or harm to others.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy, dated October 2015, available in relation to the searching of a resident, his or her belongings, and the environment in which he or she was accommodated. The policy included all of the requirements of the Judgement Support Framework, including

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she was accommodated.
- The process for the finding of illicit substances during a search.
- The consent requirements of a resident regarding searches and the process for implementing searches in the absence of consent.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on searches. Relevant staff interviewed articulated the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis was completed to identify opportunities for improvement of the search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. There had been two searches of resident property and possessions in the approved centre since the last inspection and no environmental searches. Two searches were inspected. Risk had been assessed for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre, and residents’ consent was sought and documented. Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted.
Searches were implemented with due regard to each resident’s dignity, privacy and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every search of a resident, and every property search, was available (i.e. a record of the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search).

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 14: Care of the Dying

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

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated November 2016, in relation to Care of the Dying. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere (e.g. for general health care services).
- The supports available to other residents and staff following a resident’s death.
- Advance directives in relation to end of life care, Do Not Attempt Resuscitation orders, and residents’ religious and cultural end of life preferences.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on care of the dying. Relevant staff interviewed could articulate the processes for end of life care, as set out in the policy.

Monitoring: Systems analysis is undertaken in the event of a sudden or unexpected death in the approved centre.

Evidence of Implementation: Since the last inspection no resident had required end of life care in the approved centre. One sudden death had occurred in the approved centre since the last inspection. The death of this resident was reported to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
The registered proprietor shall ensure that each resident has an individual care plan.

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

INSPECTION FINDINGS

Processes: There was a policy on individual care plans (ICPs) dated November 2016. The policy covered all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed a log to indicate that they had read and understood the policy on individual care planning. All clinical staff interviewed articulated the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members were trained in individual care planning.

Monitoring: Individual care plans were audited monthly to assess compliance with the regulation, as monthly audits of ICPs were a condition to the approved centre’s registration. A documented analysis was completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: Each resident had an ICP, and 23 ICPs were inspected. All ICPs were a composite set of documentation detailing appropriate goals, treatment, care, interventions, reviews, and resources required. The documentation was stored within each resident’s clinical file, was identifiable, uninterrupted, and not amalgamated with progress notes.

Each resident had been assessed at admission by the admitting clinician and an initial ICP was created. The ICPs were then developed by the MDT following a comprehensive assessment, as soon as was possible but within seven days of admission. Evidence-based assessments were used. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. A key-worker was not identified to ensure continuity in the implementation of the resident’s individual care plan. The MDTs reviewed ICPs at least weekly. The ICPs were updated following review, as indicated by the residents’ changing needs, condition, circumstances, and goals; this was documented.

In 5 of the 23 ICPs inspected, there was no documented evidence that the resident was offered a copy of their ICP and the reason for this was not documented. Each resident had access to their ICP and was kept informed of any changes.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
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: The approved centre had a written policy, dated November 2016, in relation to therapeutic services and programmes. The policy did not include any of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed a log to indicate that they had read and understood the policy on therapeutic services and programmes. All clinical staff interviewed articulated the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: There was evidence of ongoing monitoring of the range of therapeutic services and programmes provided to ensure that they met the assessed needs of residents. The occupational therapy department and the activities nurse monitored the groups on a regular basis and at least monthly. A documented analysis was completed to identify ways to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, and met the needs of the residents, as documented in the residents’ individual care plans (ICPs). All the therapeutic programmes and services were provided by staff who had been trained in accordance with their care delivery roles. Programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of therapeutic services and programmes provided within the approved centre was available to residents via a daily schedule of activities, displayed on whiteboards on the three wards. Residents were also given an individual programme adapted to their own needs and aligned with their care plan, goals, and interventions. Therapeutic services and programmes were provided in a separate dedicated room or in the occupational therapy department.

Each community occupational therapist facilitated a therapeutic group session once a fortnight. Social work staff facilitated a group once weekly, and they facilitated a psychoeducation group for families and carers twice yearly. There was an in-patient occupational therapist and occupational therapy assistant, and they facilitated groups and one-to-one sessions throughout the week. Also the activities nurse facilitated groups and one-to-one sessions throughout the week. The staff collaborated in the development of groups and activities and a coordinated weekly and daily timetable was evident. Evidence-based groups were facilitated to include recovery-focused group work, relaxation and anxiety management, mindfulness and exercise.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes for residents in Station A and B. There was an identified separate activities/therapy area, with three dedicated rooms, including a multi-sensory room and occupational therapy kitchen. Due to
limited space in Station C, groups had to be facilitated in the dining area, however there was an appropriate quiet room where one to one sessions could be facilitated. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Daily records were maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within each resident’s clinical file.

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

As there were no children in the approved centre who required educational services during the course of the inspection, this regulation was not applicable.

NOT APPLICABLE
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: The approved centre had a written operational policy dated November 2016 in relation to the transfer of residents. The policy detailed the requirements of the Judgement Support Framework, with the exception of the process for managing resident medications during transfer from the approved centre.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on transfers. Relevant staff interviewed could articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Transfer records were not systematically reviewed to ensure all relevant information was provided to the receiving facility. A documented analysis of transfers had not been completed.

Evidence of Implementation: The clinical files of two residents who had been transferred from the approved centre to receiving facilities, in non-emergency situations, were inspected. Documented consent of both residents to transfer was available. Residents were accompanied during the transfer.

Full and complete written information regarding both residents was transferred when they moved from the approved centre to the receiving facilities. Prior to transfer, each resident was clinically assessed, which included an individual risk assessment relating to the transfer and an assessment of the resident’s needs. This was documented and provided to the receiving facility. The clinical file recorded the documentation released to the receiving facility as part of the transfer, including the letter of referral, a list of current medications, the resident transfer form, and the required medication for the resident during the transfer process. Copies of all records relevant to the transfer process were retained in the resident’s clinical files. A checklist was not completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring and evidence of implementation pillars.
Regulation 19: General Health

(1) The registered proprietor shall ensure that:
   (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
   (b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
   (c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

Processes: There were a written general health and medical emergency policy available, which was dated November 2016. The policy included requirements of theJudgement Support Framework with the exception of the following:

The policy did not include:

- The staff training requirements in relation to Basic Life Support.
- The ongoing assessment of residents’ general health needs.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The incorporation of general health needs into the resident individual care plan.
- The documentation requirements in relation to general health assessments.

Training and Education: All clinical staff had signed a log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes set out in the medical emergency and general health care policies.

Monitoring: The recording and monitoring of resident take-up of national screening programmes was completed. A systematic review was undertaken to ensure six-monthly reviews of residents’ general health needs took place. Analysis was not completed to identify opportunities to improve general health processes.

Evidence of Implementation: In relation to responding to medical emergencies, the approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). The AED was checked weekly and this was recorded and documented.

In relation to the provision of general health services, registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care. Residents’ general health needs were monitored and assessed as indicated by their specific needs, but not less than every six months. Four residents were in the approved centre for a period of over six months and their six-monthly physical examinations were documented.
Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. Residents had access to national screening programmes that were available according to age and gender. Information was provided to residents regarding the national screening programmes available through the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy available dated October 2016 in relation to the provision of information to residents. The policy included all of the requirements of the Judgement Support Framework, with the exception of the following:

- The interpreter and translation services available within the approved centre.
- The process for identifying the residents’ preferred ways of giving and receiving information.

Training and Education: All staff had signed a log to indicate that they had read and understood the policy on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis by the activities nurse to ensure the information was appropriate and accurate, particularly where information changed, such as information on medication and housekeeping practices. A documented analysis was completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents were provided with an information handbook at admission, and it included all necessary information on housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents’ rights. In addition, the noticeboard displayed details of residents’ multi-disciplinary team (MDTs).

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. Medication information sheets and leaflets, as well as verbal information, were provided to residents in a format that was suitable to residents’ needs.

Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory because the approved centre met all the criteria of the *Judgement Support Framework* under the processes pillar.
Regulation 21: Privacy

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

### INSPECTION FINDINGS

**Processes:** The approved centre did not have a policy in place in relation to privacy.

**Training and Education:** There was no policy in place for staff to read and articulate.

**Monitoring:** There was no policy in place to review. No analysis was completed to identify opportunities to improve the processes relating to residents’ privacy and dignity.

**Evidence of Implementation:** Staff interacted with and treated residents with dignity and respect, and staff were appropriately dressed. Staff were discreet when discussing the resident’s condition and needs. The high observation area opposite the nurses’ office in station A and B, opened out on to the unit and had no walls or partitions. These areas could be fully viewed when walking through the unit. This did not afford privacy for the residents accommodated in these areas, as it was not feasible to have privacy curtains drawn at all times.

Staff reported that there was a room with a phone in station B and a private room in both Station A and C was available to make and receive calls. It was observed throughout the inspection that resident’s were making and receiving calls at the nurse’s office in all three stations. Conversations could be overheard, this did not afford privacy to residents. Noticeboards did not detail resident names or other identifiable information.

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

(a) The high observation beds near the nurses’ offices in Station A and B opened out on to the unit and had no walls or partition and this did not afford privacy for the residents accommodated in these areas.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre did not have a policy in place on premises.

Training and Education: There was no policy in place for relevant staff to read and articulate.

Monitoring: There was documented evidence that separate hygiene and ligature audits had been completed. A documented analysis was not completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was due to move to a new purpose-built facility at the end of 2017. The new facility will be based within the hospital grounds.

In the existing premises, appropriately sized communal rooms were not provided. There was one dining room for stations A and B and when all residents were in the dining room at the same time for meals then this appeared cramped and not conducive to comfort and dignity. There was one small dining room in station C, which was also used as a sitting room and activities room. The high observation areas in station A and B were open plan and could be accessed by other residents and members of the public. This was not conducive to residents comfort and privacy.

Heating was centrally controlled and could not be regulated by the residents. Heating could either be turned on or off. At the time of the inspection the weather was extremely warm and radiators remained on. This was because if the heating was turned off it could not be turned back on at night and staff reported that the unit can be cold at night. Noise levels were not excessive due to the type of design of the communal and private areas. Rooms could be ventilated when the windows were opened and lighting was adequate.
Ligature points were not minimised. Although a ligature audit was completed in October 2016 ligatures were still present throughout the unit. One of the resident’s rooms had graffiti and chewing gum on the walls. The ceiling in one of the corridors was stained. In station C, the skirting had come away, in one of the bathrooms and had not been repaired. There was also a strong smell of mould in the bathroom. Station A had a strong smell of urine in a six bedded male dormitory.

There was no scheduled programme of general maintenance and no programme of decorative maintenance. General maintenance took place following a request and records were maintained in response to issues identified. There was a cleaning schedule implemented within the approved centre.

The approved centre was not clean, hygienic, and free from offensive odours. The inspection team requested a deep clean of the bathrooms on the first day of the inspection.

Single rooms were small in size. The approved centre did not provide suitable furnishings to support resident independence and comfort. The leather sofa in the quiet room had a large tear in it. Wardrobes were not of adequate size to store resident’s property and possessions. Garden furniture was not in a good state of repair. Remote or isolated areas of the approved centre were monitored.

The approved centre was non-compliant with this regulation for the following reasons:

a) The premises were not maintained in good structural and decorative condition. One of the resident’s rooms had graffiti and chewing gum stuck to the walls. The ceiling in one of the corridors was stained. Toilets had a malodour of urine in station C, the skirting had come away in two areas in one of the bathrooms and had not been repaired. The garden furniture was in need of maintenance, 22(1)(a)

b) Premises were not adequately heated 22(1) (b)

c) There was no programme of routine maintenance and renewal of the fabric and decoration of the premises as required by this regulation, 22(1c).

d) The approved centre did not have suitable furnishings 22(2)

e) Ligature points were evident throughout the approved centre, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated November 2016 on the ordering, prescribing, storing, and administration of medicines. The policy detailed requirements of the Judgement Support Framework, with the exception of the following:

- The process for medication management at admission and transfer.
- The process for medication reconciliation.
- The process to review resident medication.
- The process for the administration of medication, including routes of medication.

Training and Education: All nursing, medical, and pharmacy staff had signed a log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes relating to ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication through the Choice and Medication website and the medication information system provided by Galway University Hospital. All nursing, medical, and pharmacy staff, where applicable, had received training on the importance of reporting medication incidents, errors, or near misses and this was documented.

Monitoring: Quarterly audits had not been conducted on residents’ Medication Prescription and Administration Records (MPARs). Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and 25 MPARs were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: resident identifiers, medications administered, route of medication, dose of medication, and frequency of medication.

The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases. A record was kept when medication was refused by or withheld from a resident. In six MPARs reviewed the allergy section had not been completed. In one MPAR, the allergy section had been completed but had not been signed by the medical practitioner.

All medication was administered by a registered nurse or registered medical professional. Controlled drugs were checked by two staff members prior to administration. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications.
Medication arriving from the pharmacist was verified against the order by a nurse to ensure it was correct and was accompanied by appropriate directions for use. Medication dispensed or supplied to the resident was stored securely in a locked unit or fridge, where appropriate. The medication trolley remained locked at all times and secured in a locked room. Medication was appropriately stored, and medication storage areas were clean and tidy. Refrigerators used for medication were used only for this purpose and a log was maintained of the temperature. An inventory of medications was kept by the pharmacist, and unused or expired medication was returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring, and evidence of implementation pillars.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: There was a written policy in place dated March 2017 and an associated safety statement in relation to health and safety. The policy and safety statement, combined, included requirements of the *Judgement Support Framework*, with the exception of the following:

- Vehicle controls.
- First aid response requirements.
- The following infection control measures:
  - Raising awareness of residents and their visitors to infection control measures.
  - Covering of cuts and abrasions.
  - Availability of staff vaccinations and immunisations.
  - Management and reporting of an infection outbreak.
  - Specific infection control measures in relation to C.difficile and Norovirus infection types.

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

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

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

The approved centre was compliant with this regulation.
Regulation 25: Use of Closed Circuit Television

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a clear written operational policy dated September 2016 in place in regard to the use of closed circuit television (CCTV). The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log to indicate that they had read and understood the policy on CCTV. Relevant staff interviewed could articulate the processes on the use of CCTV, as set out in the policy.

Monitoring: The quality of CCTV images was not checked regularly to ensure the equipment was operating appropriately. Analysis was not completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located. A resident was monitored solely for the purpose of ensuring their health, safety, and welfare. However, two CCTV cameras positioned in the internal garden areas of the approved centre were found to be recording residents’ images.

The CCTV cameras did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. The Mental Health Commission had been informed about the approved centre’s use of CCTV.

The approved centre was non-compliant with this regulation because the CCTV cameras were capable of recording and storing a resident’s image. Specifically, two CCTV cameras positioned in internal garden areas of the approved centre were found to be recording residents’ images, 25(1)(d).
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: The approved centre had a policy on staffing, dated November 2016, and it also adopted the HSE’s generic national recruitment policy, dated 2009, and there was a written statement to this effect. The policy and procedures related to the recruitment, selection and vetting of staff. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The required qualifications of training personnel.
- The staff performance and evaluation requirements.
- The process for transferring responsibility from one staff member to another.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The number and skill mix of staff had not been reviewed against the levels recorded in the approved centre’s registration. Nurse staffing levels are monitored on a daily basis in relation to resident’s needs. Analysis was completed.

Evidence of Implementation: There was an organisational chart in place for the approved centre to identify the leadership and management structure and the lines of authority and accountability of staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. There was no written staffing plan for the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs. Staff had the appropriate qualification to do their jobs. A planned and actual staff rota was maintained and it showed that an appropriately qualified staff member was on duty and in charge at all times. This was documented.

Staff were trained in accordance with the assessed needs of the resident group profile and of individual residents. Gaps were identified in the staff training plan in relation to specific training such as intellectual disability training and also the required training as identified by this regulation.
Not all clinical staff had up-to-date training in the following:
- Fire safety.
- Basic Life Support.
- Management of violence and aggression (e.g. Therapeutic Crisis Intervention/Professional Management of Aggression and Violence (PMAV)).
- The Mental Health Act 2001.

All staff training was documented and staff training logs were maintained. The Mental Health Act 2001 and Mental Health Commission rules and codes and all other Mental Health Commission documentation and guidance were made available to staff throughout the approved centre.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>ADON</td>
<td>1</td>
<td>1 (On call)</td>
</tr>
<tr>
<td></td>
<td>CNM3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Stations A, B and C</td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OT Assistant</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Assistant Director of Nursing (ADON), Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

The approved centre was non-compliant with this regulation because not all health care professionals were up to date with required training in fire safety, Basic Life Support, PMAV or equivalent and the Mental Health Act 2001, 26(4)
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated March 2017, in relation to the of records. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff and other relevant staff had signed a log to indicate that they had read and understood the policy relating to the maintenance of records. All clinical staff and other relevant staff interviewed could articulate the processes for the creation of, access to, retention of, and destruction of records as set out in the policy. Not all clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process, insofar as was practicable. Analysis was completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: All resident records were physically stored together where possible. A record was initiated for every resident assessed or provided with care and services by the approved centre. Resident records were up to date and were reflective of residents’ current status and the care and treatment being provided. Only authorised staff made entries into resident records, which were appropriately secured throughout the approved centre.

Six clinical files were inspected. Not all of these files were in good order. Four residents’ clinical files contained loose pages. Five clinical files had entries which did not include the date and time using the 24-hour clock. The approved centre did not maintain a record of all signatures used in the resident record. When an error was made on resident records, this was not scored out with a single line and the correction written alongside, with the date, time, and initials. One clinical file had numerous loose letters with the residents name on them. One clinical file did not have resident identifiers on 12 continuous pages of progress notes.

Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.
The approved centre was non-compliant with this regulation for the following reasons:

(a) Four residents’ records contained loose pages, 27(1).

(b) 12 pages of progress notes did not record any form of identification 27(1).

(c) One clinical file had numerous loose letters addressed to the resident within the clinical file 27(1).
**Regulation 28: Register of Residents**

<table>
<thead>
<tr>
<th>NON-COMPLIANT</th>
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<tbody>
<tr>
<td>Quality Rating</td>
</tr>
<tr>
<td>Risk Rating</td>
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</tbody>
</table>

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

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

**INSPECTION FINDINGS**

The approved centre had an up-to-date register of residents. It was a hard-copy book and was available to the Mental Health Commission on inspection. The register did not include all of the information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically the register did not consistently record, date of discharge, ethnic or cultural background, next of kin/representative, diagnosis on discharge and diagnosis on admission.

The approved centre was non-compliant with this regulation because the register of residents did not contain all of the information required under Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006,28 (2).
### Regulation 29: Operating Policies and Procedures

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

### INSPECTION FINDINGS

**Processes:** There was no policy in place in relation to operating policies and procedures.

**Training and Education:** There was no policy in place for staff to read and articulate. Relevant staff were trained on the approved centre’s operational policies and procedures through the Q-Pulse electronic quality management system. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies.

**Monitoring:** An annual audit was not undertaken to determine compliance with review time frames. Analysis was not completed to identify opportunities to improve the processes for developing and reviewing policies.

**Evidence of Implementation:** The approved centre had adopted the Health Service Executive’s generic national recruitment policies, and there was a written statement to this effect. Any generic policies used were appropriate to the approved centre and the resident group profile. The operating policies and procedures were developed with input from nursing, clinical, and business staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. All operating policies and procedures required by the regulations were appropriately approved by the executive management team, were up to date, and were reviewed within three years.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
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:** The approved centre had a policy on Mental Health Tribunals, dated March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed a log to indicate that they had read and understood the policy on Mental Health Tribunals. Relevant staff were able to articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

**Monitoring:** Analysis was not completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

**Evidence of Implementation:** The approved centre provided facilities and resources to support the Mental Health Tribunals process. It had a dedicated tribunal’s room and a private meeting area for solicitors and patients. It was also possible to hold tribunals in station C where necessary. Staff accompanied and assisted patients to attend their tribunals as necessary.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated October 2015 in relation to the management of complaints. It also used the HSE’s Your Service, Your Say policy and procedures. The policies, combined, included all of the requirements of the Judgement Support Framework. The process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in, or on behalf of, an approved centre, was detailed in the policy.

Training and Education: Relevant staff were trained in the complaints management process. All staff had signed a log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: There was documented evidence that an audit of complaints in the wider service was completed, but these audits were not specific to the approved centre. Complaints data had been analysed, discussed, and considered by senior management, with required actions identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Residents were provided with the complaints policy and procedure at admission or soon thereafter. The information was provided within the resident information booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

A record of all complaints was maintained, including minor complaints. Minor complaints were escalated to the complaints officer if they could not be resolved. All complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and
outcomes, were fully recorded and kept distinct from the resident’s individual care plan. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint been made. The complainant’s satisfaction or dissatisfaction with the investigation findings was not documented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring and evidence of implementation pillars.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: There was a risk management policy in place dated October 2016. The policy included the policy related regulation requirements, and the requirements of the Judgement Support Framework with the exception of the following:

- Capacity risks relating to the number of residents in the approved centre.
- The responsibilities of the registered proprietor in relation to risk management and the implementation of the risk management policy.

Training and Education: Relevant staff were trained in the identification, assessment, and management of risk. Staff were trained in health and safety risk management. Clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. Not all staff were trained in incident reporting and documentation. All staff interviewed could articulate the risk management processes, as set out in the policy. The Q-Pulse system indicated that all staff had read and understood the risk management policy. All training was documented.

Monitoring: The risk register was not audited to determine compliance with the approved centre’s risk management policy. All incidents in the approved centre were recorded on the National Incident Management System (NIMS) and risk-rated. Analysis of incident reports was completed to identify opportunities for improvement of risk management processes.

Evidence of Implementation: The person with responsibility for risk, the quality and risk advisor, was identified and known by all staff.
Ligature points, were not removed or effectively mitigated and this was indicated on the risk register and the ligature audit. The approved centre aimed to move to a purpose built premises in December 2017.

Clinical risks and corporate risks were identified, assessed, treated, reported, and monitored. Clinical risks were documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, and monitored by the approved centre in accordance with relevant legislation. Health and safety risks were documented within the risk register, as appropriate. A health and safety subcommittee met monthly in the approved centre.

Multi-disciplinary teams were involved in the development, implementation, and review of risk management processes. Individual risk assessments were completed prior to and during episodes of resident seclusion and physical restraint, at admission to identify individual risk factors, prior to transfer and discharge, and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format via NIMS. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

The approved centre had up-to-date insurance. It indicated that coverage was provided under the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.

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

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

INSPECTION FINDINGS

There was an up-to-date certificate of registration with two associated conditions displayed in a prominent position, outside station A of the approved centre.

The approved centre was compliant with this regulation.
10.0 Inspection Findings – Rules

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

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

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

INSPECTION FINDINGS

Processes: The approved centre had an operational policy, dated June 2016, and procedures in place in relation to the use of Electro-Convulsive Therapy (ECT). The policy, which was reviewed annually, included all of the relevant criteria of this rule. The procedures in place included the following:

- How and where Dantrolene was stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hyperthermia.
- The obtaining of consent for the maintenance and continuation of ECT.

Training and Education: All staff involved in ECT were trained in line with international best practice and had appropriate training in Basic Life Support.

Monitoring: ECT was monitored as part of the approved centre’s accreditation with the ECT Accreditation Service (ECTAS)

Evidence of Implementation: The approved centre had a dedicated ECT suite, a private waiting room, an adequately equipped treatment room, and a recovery room. The recovery room was of adequate size to accommodate patients receiving ECT. There was a facility to monitor Electroencephalogram (EEG) on two channels, and the machines were regularly maintained. The ECT material and equipment was in line with best international practice. There were up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia, which were prominently displayed.

The clinical files of two patients who had received ECT were examined, it indicated that appropriate information about ECT was given to the patients by the consultant psychiatrist, including details of likely adverse effects of ECT treatment. The information provided was in clear and simple language that the patients could understand. The patients were informed of their right to have an advocate and had the opportunity to ask questions at any time.

Following an assessment of capacity by the consultant psychiatrist, both patients were assessed as not having capacity to give informed consent for ECT. A Form 16, Treatment without Consent Electroconvulsive Therapy Involuntary Patient (Adult), was completed for both patients. Copies were in each resident’s clinical file. Both copies were sent to the Mental Health Commission within 5 days.
Both programmes of ECT were prescribed by the consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies before prescribing ECT, the communication with the patient and/or next of kin, mental state examinations, and the assessments completed before and after ECT treatment. Pre-anaesthetic assessments were documented in the clinical files and anaesthetic risk assessments were recorded. The ECT record was retained in the clinical file, as well as all post ECT assessments.

The approved centre was compliant with this rule.
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

(4) In this section “patient” includes –
   (a) a child in respect of whom an order under section 25 is in force, and
   (b) a voluntary patient.

INSPECTION FINDINGS

Processes: The approved centre had a written policy, dated October 2016, in relation to the use of seclusion. The policy was reviewed annually. There was a separate written policy and procedures for training staff in relation to seclusion, and a separate policy in relation to the use of CCTV. CCTV was not used in the seclusion facility of this approved centre. The policies, combined, included all of the relevant guidance criteria of this rule governing the use of seclusion.

Training and Education: The approved centre maintained a written record indicating that all staff involved in the use of seclusion had read and understood the policy. Records were maintained of staff attendance at training and were made available to the inspection team.

Monitoring: An annual report on the use of seclusion had been completed and was available for inspection.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings that did not endanger resident safety. The seclusion room was not used as a bedroom.

The clinical files of two patients who had been in seclusion were inspected. The approved centre complied with the rule governing the use of seclusion. In both episodes, seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified of the use of seclusion within the appropriate time frame and this was recorded in the clinical file. Seclusion was only implemented in the patients’ best interests and in rare and exceptional circumstances, where the residents posed immediate and serious harm to themselves or others. The use of seclusion was based on a risk assessment of the patients. Cultural awareness and gender sensitivity were demonstrated.

Each resident was informed of the reasons, duration, and circumstances leading to the discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour. Both episodes of seclusion were recorded in the residents’ clinical files and all uses of seclusion were recorded in the seclusion register. A copy of the seclusion register was placed within the residents’ clinical files and made available to inspectors.
The approved centre was compliant with this rule.
Section 69: The Use of Mechanical Restraint

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

INSPECTION FINDINGS

As mechanical restraint was not used in the approved centre, this rule was not applicable.
11.0 Inspection Findings – Mental Health Act 2001

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

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

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

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

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

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

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

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

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

INSPECTION FINDINGS

The files of three patients were inspected against in relation to Part 4 of the Mental Health Act 2001: Consent to Treatment. Two patients were assessed as being capable of providing consent to treatment and their clinical files evidenced the following:

- The responsible consultant psychiatrist had undertaken a capacity assessment, which was documented.
- There was a record of each patient’s consent that contained
  - A written record of the name of specific medications prescribed.
  - Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Details were provided of discussion with the patients, including
  - The nature and purpose of the medication(s).
  - The effects of medication(s), including risks and benefits and views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
The third patient were deemed to not have capacity to consent to treatment. The Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent within the clinical file contained the following information:

- The names of the medication prescribed.
- Confirmation of the assessment of the patients’ ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of any discussion with the patient, including
  - The nature and purpose of the medication(s).
  - The effects of the medications(s), including any risks and benefits.
  - Any views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
  - Authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
12.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in place, dated March 2017, in relation to the use of physical restraint and the management of aggression and violence, and it was reviewed annually. There was a separate policy and procedures in relation to staff training on physical restraint. The policies, combined, met all of the criteria of this code of practice, with the exception of the areas to be addressed during training and alternatives to physical restraint training in Professional Management of Aggression and Violence (PMAV) and breakaway techniques.

Training and Education: The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy. A record of attendance at training was maintained. Physical restraint was not used to ameliorate staff shortages.

Monitoring: An annual report on the use of physical restraint I the approved centre had been produced.

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident’s unsafe behaviour. Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint. Each of the four residents was informed of the reasons for, the duration of and circumstances leading to the discontinuation of physical restraint. All three episodes of physical restraint lasted less than three minutes.

The approved centre was non-compliant with this code of practice because:

(a) The training-related policy did not outline the areas to be addressed during training including training in the prevention and management of violence and aggression, “breakaway” techniques and alternatives to physical restraint 10 (1) (b).
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 FINDING

This code of practice was not applicable.
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.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre had a risk management policy dated October 2016, which met all of the policy criteria of this code of practice.</td>
<td></td>
</tr>
<tr>
<td><strong>Training and Education:</strong> Staff had signed the policy signature sheet to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes relating to the notification of deaths and incidents, as set out in the policy.</td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring:</strong> Deaths and incidents were reviewed to identify and correct any problems as they arose and to improve quality.</td>
<td></td>
</tr>
<tr>
<td><strong>Evidence of Implementation:</strong> There had been one death in the approved centre since the last inspection, and the death was notified to the Mental Health Commission within 48 hours. There was an incident reporting system in place. A standardised incident report form was used. A six-monthly summary of all incidents was provided to the Mental Health Commission. The approved centre was compliant with Article 32 of the Regulations.</td>
<td></td>
</tr>
<tr>
<td>The approved centre was compliant with this code of practice.</td>
<td></td>
</tr>
</tbody>
</table>
INSPECTION FINDINGS

Processes: The approved centre had policies and protocols in place for staff working with people with intellectual disabilities. The policies reflected person-centred treatment planning and presumption of capacity. Least restrictive interventions were detailed in the policies. There was a policy on the management of problem behaviours. Roles and responsibilities of staff were included in the policy. There was a communication protocol in place to ensure appropriate and relevant communication and close liaison with external agencies for people with intellectual disabilities. There was a policy and procedures for training of staff in working with people with intellectual disabilities. The policies, combined, met all of the criteria of this code of practice.

Training and Education: The education and training provided did not support the principles and guidance in the code of practice. Only one staff member had been trained to work with people with intellectual disabilities. Education and training did not include person-centred approaches or relevant human rights principles, and it did not focus on preventative responsive strategies to problem behaviours.

Monitoring: The policies were reviewed every three years. The use of restrictive practices was not reviewed periodically in accordance with the policies.

Evidence of Implementation: The clinical file of one resident with a diagnosed intellectual disability was inspected. There was no evidence in the clinical file of inter-agency collaboration to ensure a smooth transition from one service to another. The individual care plan (ICP) did not describe the levels of support and treatment required to support the service user’s journey to recovery, in line with the resident’s assessed needs and in consideration of the resident’s environment, available resources, and supports.

An assessment of the resident took place but it was not comprehensive because the clinical file showed the resident was not assessed on social, interpersonal and physical environment-related issues; communication difficulties; or performance capacities and difficulties. The assessment included details of the resident’s medical, psychiatric, and psychosocial history and medication (historic and current), as well as a mental state assessment and a risk assessment. The resident was assigned a key worker and had an ICP. There was no documented evidence that a functional assessment of capacity and documentation of same was carried out.

The mental health care and treatment was provided in the least restrictive environment, consistent with the resident’s needs. In relation to communication issues, the resident’s preferred ways of giving and receiving information were not documented in the ICP. Information given to the resident was not appropriate or accessible. The resident’s understanding of information was not documented.

The resident had opportunities to engage in meaningful activities. The involvement of the resident’s family, carer, or advocate was actively encouraged to facilitate communication.
The approved centre was non-compliant with this code of practice for the following reasons:

a) The use of restrictive practices was not reviewed periodically in accordance with the policies, 5.3(b).

b) The education and training provided did not support the principles and guidance in the code of practice as only one staff member had been trained in intellectual disabilities, 6.0.

c) Education and training did not include person-centred approaches or relevant human rights principles, and it did not focus on preventative responsive strategies to problem behaviours, 6.1.

d) There was no evidence in the clinical file of inter-agency collaboration to ensure a smooth transition from one service to another, 7.1.

e) The assessment of the resident was not comprehensive as the resident was not assessed in terms of social, interpersonal, and physical environment-related issues; communication difficulties; or performance capacities and difficulties, 8.2.

f) The ICP did not describe the levels of support and treatment required to support the resident’s journey to recovery, in line with the resident’s assessed needs and in consideration of the resident’s environment, available resources, and supports, 8.3.

g) In relation to communication issues,
   - The resident’s preferred way of giving and receiving information were not documented in the ICP, 9.1.
   - Information given was not appropriate or accessible, 9.2.
   - The resident’s understanding of information was not documented, 9.6.

h) In relation to capacity issues, there was no documented evidence that a functional assessment of capacity and documented of same was carried out, 12.2 and 12.3.
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

Processes: An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy met the criteria of this code of practice, and it was reviewed annually. The ECT procedures in place included the following:

- How and where Dantrolene was stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hyperthermia.
- Obtaining consent for the maintenance and continuation of ECT.

Training and Education: All staff involved in ECT were trained in line with international best practice and had appropriate training, including Basic Life Support.

Monitoring: ECT was monitored as part of the approved centre’s accreditation with the ECT Accreditation Service (ECTAS).

Evidence of Implementation: Two residents had received ECT under the code of practice, and their clinical files were examined. The residents were given an easy-to-read and understand ECT booklet, and a verbal explanation by the consultant psychiatrist prior to consent. The resident was provided with all the required information specified in section 4.1 of this code of practice. Information was provided on the likely adverse effects of ECT. Resident consent was documented in relation to each episode of ECT treatment.

The approved centre had a dedicated ECT suite, a private waiting area was provided, an adequately equipped treatment room, and a recovery room. The recovery room was of adequate size to accommodate the number of residents receiving ECT. There was a facility to monitor EEG on two channels and the machines were regularly maintained. The material and equipment was in line with best international practice.

There were up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia, which were prominently displayed. There was a named consultant psychiatrist responsible for ECT management, a named consultant anaesthetist with overall responsibility for ECT, and one designated ECT nurse. Post-ECT assessments (clinical status and progress) were recorded in the residents’ clinical files after each treatment. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was compliant with this code of practice.
Admission, Transfer and Discharge

Non-compliant
Risk Rating: Low

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

INSPECTION FINDINGS

Processes: The approved centre had admission, transfer, and discharge policies in place.

Admission: The admission policy was dated November 2016 and set out the protocols for residents’ planned admissions and urgent referrals. The policy met all of the policy criteria of this code of practice. It included the procedure for the admission of an involuntary patient and for residents who self-present. The policy outlined the roles and responsibilities of multi-disciplinary team (MDT) staff in relation to resident assessment after admission.

Transfer: There was a policy on transfer dated November 2016. It met all of the policy criteria of this code of practice. It set out the roles and responsibilities of staff in relation to the transfer of residents and included procedures for involuntary transfer. The arrangement of transfers, provisions for emergency transfer, the transfer of residents abroad, and the safety of residents and staff during transfer were detailed in the policy.

Discharge: The discharge policy was dated January 2014. It met all of the policy criteria of this code of practice. The policy included the process for the supply of medication. The protocol for discharging homeless people, the procedures for management of discharge against medical advice, the protocol for discharge of people with an intellectual disability, and the protocol for the discharge of older people were detailed in the policy. The policy included the roles and responsibilities of staff in providing follow-up care and a method of following up and managing missed appointments. The procedures for the discharge of involuntary patients and people with an intellectual disability were detailed in the policy.

Training and Education: There was documented evidence that staff had read and understood the policies on admission, transfer, and discharge.

Monitoring: An audit of the implementation of and adherence to the admission and discharge policies was not completed to ensure the policies were being fully and effectively implemented and adhered to in clinical practice.

Evidence of Implementation: The approved centre’s admission, transfer, and discharge policies were compliant under Regulation 32: Risk Management Procedures.

Admission: The approved centre’s admission process complied under the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Personal Property and Possessions, Regulation 15: Individual Care Plan, and Regulation 20: Provision of Information to Residents. The approved centre’s admission process did not comply under Regulation 27: Maintenance of Records. The clinical files of three residents were inspected in relation to the admission process. The admission assessment was comprehensive in each case. All assessments and examinations were documented within each clinical file, and each resident was assigned a key worker.
Transfer: The approved centre’s transfer process was compliant under Regulation 18: Transfer of Residents. The files of two residents who had been transferred for specialist treatment in two other facilities were inspected. The decision to transfer the residents was made by a registered medical practitioner and was agreed with the receiving facility. A risk assessment was conducted prior to transfer, and efforts were made to respect the residents’ wishes and obtain consent for the transfer. Residents’ representatives were involved in the transfer process where appropriate. Copies of the referral letters were kept in the respective clinical files.

Discharge: The file of one resident who had been discharged was inspected. A discharge plan was in place as part of the individual care plan (ICP). It included the estimated date of discharge, documented communication with primary care, and a follow-up plan. Early warning signs of relapse and risk factors were documented in the discharge plan. A discharge meeting took place prior to the resident discharge and this was attended by the resident, the key worker, the relevant members of the MDT, and the resident representative. A comprehensive assessment was completed prior to discharge, and it included documented psychiatric and psychological needs, a mental state exam, and a risk management plan. The discharge was coordinated by the resident’s key worker and comprehensive discharge summaries were issued within 14 days. These summaries contained details of the resident’s diagnosis, prognosis, medication, and follow-up arrangements.

The approved centre was non-compliant with this code of practice for the following reasons:

a) The admission process did not comply under Regulation 27: Maintenance of Records, 22.6.

b) An audit of the implementation of and adherence to the admission and discharge policies was not completed to ensure the policies were being fully and effectively implemented and adhered to in clinical practice, 4.19.
### Appendix 1: Corrective and Preventative Action Plan Template

**Regulation 21: Privacy**  
Report reference: Page 39

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring¹ or New² area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition³</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>1. The high observation beds near the nurses’ offices in Station A and B opened out on to the unit and had no walls or partition and this did not afford privacy for the residents accommodated in these areas.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Surround curtains in place and monitored by staff. Move to new premises pending, with single ensuite accommodation. Post-Holder(s) responsible: Clinical Nurse Manager 11</td>
<td>Checklist maintained by CNM 11. Transition group in place monitoring project progress and reports to MHC.</td>
<td>Feasible</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Preventative Action(s): Restricted access to ward areas monitored by nursing staff. Visitor policy in place. Post-Holder(s) responsible: Clinical Nurse Manager 11</td>
<td>Controlled access to ward areas facilitated by nursing staff. Staff have access to all policies on Qpulse and verification process in place noting staff have</td>
<td>Feasible</td>
</tr>
</tbody>
</table>

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¹ Area of non-compliance reoccurring from 2016  
² Area of non-compliance new in 2017  
³ Not applicable
2. Residents did not have privacy when making and receiving phone calls.

| New | Plan required | Corrective Action(s): Confirmation that there is a designated room on each station available for residents to make private phone calls. | Mutual Support Meeting (forum for residents to raise issues) minutes reviewed at CNM meeting. Complaints procedure in place. Complaints log reviewed.

Post-Holder(s) responsible: CNM 11 |

| Preventative Action(s): Staff are mindful of facilitating residents to utilise private areas. | Agenda item at CNM meeting. | Feasible | Immediately |

| Post-Holder(s) responsible: CNM 11 |
### Regulation 22: Premises

**Report reference: Page 40-41**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The premises were not maintained in good structural and decorative condition. One of the resident’s rooms had graffiti and chewing gum stuck to the walls. The ceiling in one of the corridors was stained. Toilets had a malodour of urine in station C, the skirting had come away in two areas in one of the bathrooms and had not been repaired. The garden furniture was in need of maintenance.</td>
<td>Reoccurring</td>
<td>No plan required, monitor as per Condition²</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Premises were not adequately heated.</td>
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<tr>
<td>5. There was no routine maintenance and renewal of the fabric and decoration of the premises as required by this regulation.</td>
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<td>6. The approved centre did not have suitable furnishings.</td>
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<tr>
<td>7. Ligature points were evident throughout the approved centre.</td>
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</tr>
</tbody>
</table>

² The approved centre shall submit a plan to the Mental Health Commission for the closure of the approved centre, including the transfer or discharge of all current residents. The approved centre shall provide updates on the closure plan in a form and frequency prescribed by the Commission. The updates shall include ongoing maintenance to be undertaken on the approved centre premises up until all residents have been transferred or discharged.
### Regulation 25: The Use of Closed Circuit Television

*Report reference: Page 45*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016, or monitored as per Condition</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>8. The CCTV cameras were capable of recording and storing a resident’s image. Specifically, two CCTV cameras positioned in internal garden areas of the approved centre were found to be recording residents’ images.</td>
<td>Reoccurring</td>
<td>Please include confirmation of actions taken as per your correspondence of 26 June 2017.</td>
<td>Corrective Action(s): CCTV cameras no longer recording in area with exception of exit points. Post-Holder(s) responsible: CNM11</td>
<td>System checked regularly. Controlled access to alter system.</td>
<td>Some tension exists between Coroner’s recommendation and MHC.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s): System checked regularly. Controlled access to alter system. Post-Holder(s) responsible: CNM11</td>
<td>Routine checks by CNM via visual inspection.</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Report reference: Page 46-47**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>9. Not all health care professionals were up to date with required training in fire safety, Basic Life Support, PMAV or equivalent and the Mental Health Act 2001.</td>
<td>Reoccurring</td>
<td>A new plan is required</td>
<td>Corrective Action(s): Training schedule to ensure all staff have adequate training. Train the trainer course scheduled to facilitate in service training across all disciplines. Post-Holder(s) responsible: All heads of Discipline. Preventative Action(s): Log to be maintained by head of Discipline. Post-Holder(s) responsible:</td>
<td>As above.</td>
<td>As above</td>
</tr>
</tbody>
</table>

- **Achievable / Realistic**
  - Provide corrective and preventative action(s) to address the area of non-compliance
  - Provide the method of monitoring the implementation of the action(s)
  - Provide details of any barriers to the implementation of the action(s)

- **Time-bound**
  - Provide the timeframe of the completion of the action(s)

- **Last Quarter 2017**
### Regulation 27: Maintenance of Records

**Report reference:** Page 48-49

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
<td><strong>Taken from the inspection report</strong></td>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>10. Four residents’ records contained loose pages.</td>
<td>Reoccurring</td>
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<tr>
<td>11. 12 pages of progress notes did not record any form of identification.</td>
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<tr>
<td>12. One clinical file had numerous loose letters addressed to the resident within the clinical file.</td>
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</tr>
<tr>
<td>The update of January 2017 reported that ‘the systems for maintenance of records are currently being reviewed by working group and we await their recommendations’. A new plan is required.</td>
<td>Corrective Action(s): Funding to be sought for extra ward clerk resource. Stronger paper resource to be used in clinical files as approved at Clinical Governance committee. Monitoring at each MDT meeting Post-Holder(s) responsible: Registered Proprietor</td>
<td>Audit of records.</td>
<td>Dependent on provision of additional ward clerk hours.</td>
<td>Feasible</td>
<td>When funding obtained.</td>
</tr>
<tr>
<td>Preventative Action(s): Monitoring at each MDT meeting. Group in place to monitor the maintenance of records. Post-Holder(s) responsible: Chair of Group.</td>
<td>As above</td>
<td></td>
<td></td>
<td>Feasible</td>
<td>Immediate</td>
</tr>
</tbody>
</table>
**Regulation 28: Register of Residents**

*Report reference: Page 50*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>13. The register of residents did not contain all of the information required under Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.</td>
<td>Reoccurring</td>
<td>A new plan is required</td>
<td>Corrective Action(s): Daily review and monitoring of Register and updating as missing information becomes available. Post-Holder(s) responsible: CNM11</td>
<td>By inspection</td>
<td>Achievable</td>
</tr>
</tbody>
</table>

Corrective Action(s): Daily review and monitoring of Register and updating as missing information becomes available. Preventative Action(s): As above Post-Holder(s) responsible: CNM11 | As above | As above | Immediate |
### Code of Practice: The Use of Physical Restraint

**Report reference: Page 68**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>14. The training-related policy did not outline the areas to be addressed during training including training in the prevention and management of violence and aggression, “breakaway” techniques and alternatives to physical restraint.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Update Training policy  Post-Holder(s) responsible: Practice and Development Coordinator</td>
<td>Updated policy will be approved by the Management Team</td>
<td>Achievable</td>
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<tr>
<td></td>
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<td>Preventative Action(s): Policy group in place to review policies at the specified date. All staff may contribute to policies under review.  Post-Holder(s) responsible: Practice and Development Coordinator</td>
<td>Policy Group report to Clinical Governance Committee meetings.</td>
<td>As above</td>
</tr>
</tbody>
</table>
15. The use of restrictive practices was not reviewed periodically in accordance with the policies.

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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>15. The use of restrictive practices was not reviewed periodically in accordance with the policies.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Review of need for restrictive practices is completed in keeping with resident’s individual needs and individual care plan updated accordingly. Post-Holder(s) responsible: Consultant psychiatrist and MDT members</td>
<td>Care plan audit</td>
<td>Achievable</td>
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<td></td>
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<td></td>
<td>Preventative Action(s): Staff verification of reading and understanding policies for implementation. Post-Holder(s) responsible: Heads of Discipline All staff</td>
<td>Monitoring of verification log.</td>
<td>Achievable</td>
</tr>
<tr>
<td>16. The education and training provided did not support the principles and guidance in the code of practice as only one staff member had been</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Provide training for staff in keeping with the Code of Practice. Post-Holder(s) responsible: Practice Development Coordinator</td>
<td>Certificates of Attendance/ Completion kept on file. Training log reviewed</td>
<td>Achievable</td>
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<tr>
<td><strong>17.</strong> Education and training did not include person-centred approaches or relevant human rights principles, and it did not focus on preventative responsive strategies to problem behaviours.</td>
<td>Corrective Action(s): Provide training for staff in keeping with the Code of Practice Post-Holder(s) responsible: Practice Development Coordinator</td>
<td>Heads of Discipline to monitor training logs and course content through relevant existing disciplinary meetings.</td>
<td>Achievable</td>
<td>Last Quarter 2017.</td>
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<tr>
<td><strong>18.</strong> There was no evidence in the clinical file of inter-agency collaboration to ensure a smooth transition from one service to another.</td>
<td>Corrective Action(s): Review of need for interagency collaboration is completed in keeping with resident’s individual needs and individual care plan updated accordingly. Post-Holder(s) responsible: Consultant Psychiatrist and MDT members</td>
<td>Care plan audit</td>
<td>Achievable</td>
<td>Immediate</td>
<td></td>
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<tr>
<td>New</td>
<td>Plan required</td>
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</tbody>
</table>
| New | Plan required | Preventative Action(s): Case conferences and discharge planning  
Post-Holder(s) responsible: Consultant Psychiatrist and MDT members | Discharge checklist in place | Achievable | Immediate |
|---|---|---|---|---|
| New | Plan required | Corrective Action(s): Assessment of resident is completed in keeping with resident’s individual needs and individual care plan updated accordingly, by MDT members. Circulate code of practice to all MDTs to ensure these issues are addressed.  
Post-Holder(s) responsible: MDT members  
Clinical Director | Care plan audit  
Ongoing monitoring and review of resident. | Achievable | Immediate |
| New | Plan required | Preventative Action(s): Training and Education  
Post-Holder(s) responsible: Heads of Discipline | Certificate of completion for file and training log updated and reviewed. | Achievable | Ongoing |
<p>| New | Plan required | Corrective Action(s): Assessment of resident is completed in keeping with resident’s individual needs and individual care plan | Care plan audit | Achievable | Immediate |</p>
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<td>line with the resident’s assessed needs and in consideration of the resident’s environment, available resources, and supports.</td>
<td>updated accordingly, by MDT members</td>
<td>Preventative Action(s): Staff vigilance in care plan development and documentation</td>
<td>Care plan audit</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: MDT members</td>
<td>Post-Holder(s) responsible: MDT members</td>
<td>Anticipatory Action(s): Staff vigilance in care plan development and documentation</td>
<td>Achievable</td>
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<td>Immediate</td>
</tr>
<tr>
<td>21. In relation to communication issues, The resident’s preferred way of giving and receiving information were not documented in the ICP, Information given was not appropriate or accessible, and The resident’s understanding of information was not documented.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Assessment of resident is completed in keeping with resident’s individual needs and individual care plan updated accordingly, by MDT members</td>
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<td></td>
<td></td>
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<td>22. In relation to capacity issues, there was no documented evidence</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Assessment of resident is completed in keeping with resident’s individual needs and individual care plan updated accordingly, by MDT members</td>
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<td></td>
<td></td>
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that a functional 
assessment of capacity 
and documented of same 
was carried out.

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<tr>
<td>resident’s individual needs and individual care plan updated accordingly, by MDT members</td>
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</tr>
<tr>
<td>Post-Holder(s) responsible: Consultant Psychiatrist and relevant MDT members</td>
<td></td>
<td></td>
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<tr>
<td>Preventative Action(s): Staff vigilance in care plan development and documentation</td>
<td>Care plan audit</td>
<td>Achievable</td>
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<tr>
<td>Post-Holder(s) responsible: MDT members</td>
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</table>
## Code of Practice: Admission, Transfer and Discharge

**Report reference: Page 74-75**

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<tr>
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23. An audit of the implementation of and adherence to the admission and discharge policies was not completed to ensure the policies were being fully and effectively implemented and adhered to in clinical practice.

- **New Plan required**
  - **Specific**
    - Corrective Action(s): Audit to be conducted
      - Post-Holders responsible: Chair of Approved Centre Audit Committee and committee members
    - Preventative Action(s): Staff verification of reading and understanding policies and implementation.
      - Post-Holders responsible: Heads of Discipline
      - All staff
  - **Measureable**
    - Audit
  - **Achievable / Realistic**
    - Achievable
  - **Time-bound**
    - Last Quarter 2017.