Ashlin Centre

ID Number: AC0094

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Ashlin Centre
HSE North Dublin Mental Health Services
Beaumont Road
Dublin 9

Conditions Attached:
Yes

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

Registered Proprietor:
HSE

Most Recent Registration Date:
16 May 2017

Registered Proprietor Nominee:
Ms Anne Marie Donohue, General Manager, Mental Health Services, CHO DNCC

Inspection Team:
Dr Enda Dooley, MCRN004155, Lead Inspector
Leon Donovan
Mary Connellan
Noeleen Byrne

Inspection Date:
19 – 22 June 2018

Inspection Type:
Unannounced Annual Inspection

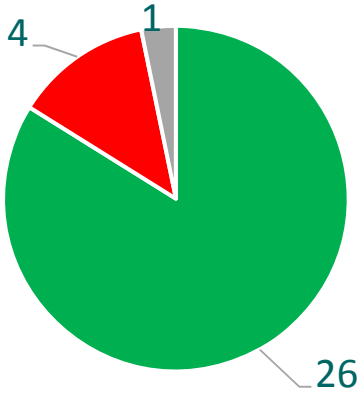
Previous Inspection Date:
10 – 13 October 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

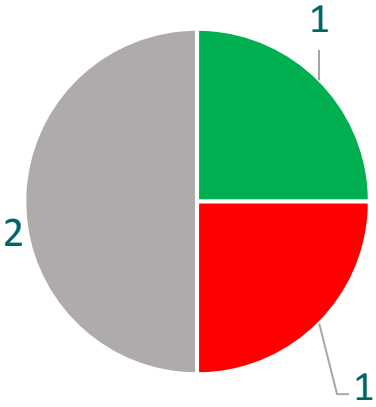
Date of Publication:
17 January 2019

2018 COMPLIANCE RATINGS

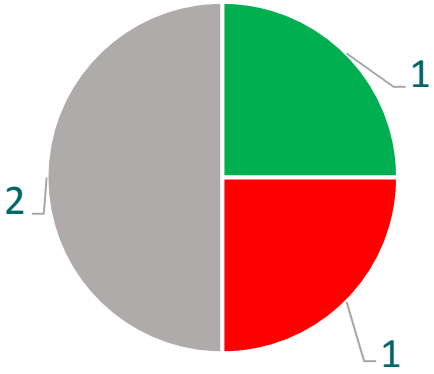
REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH



CODES OF PRACTICE

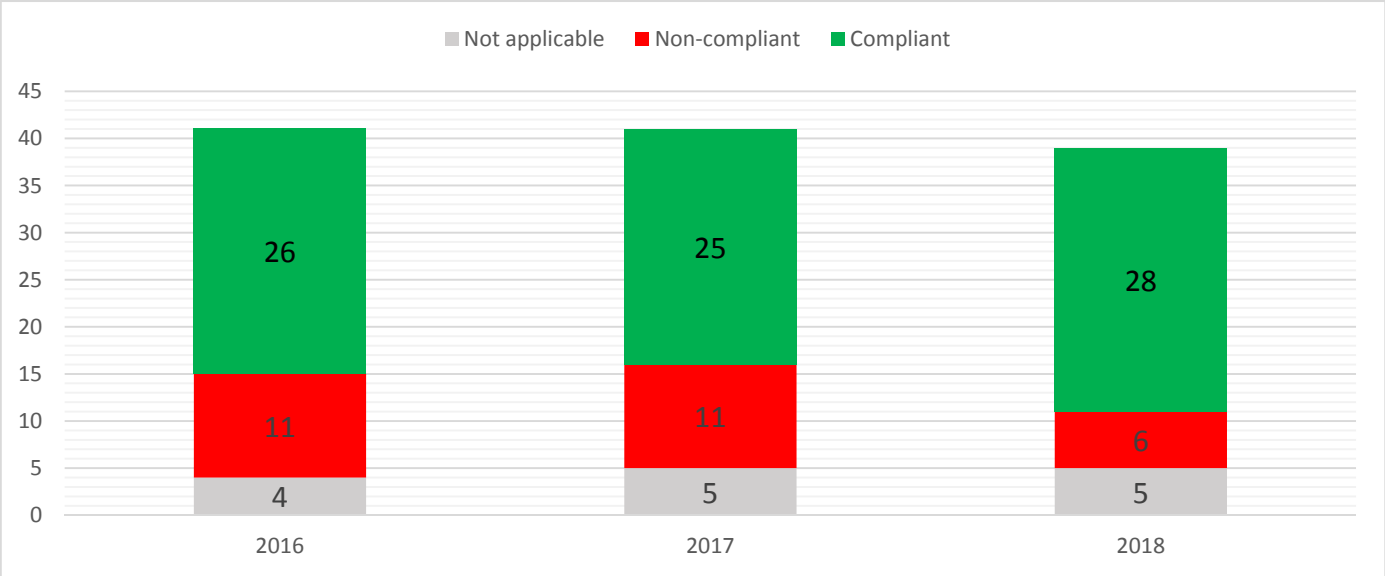


Compliant
Non-compliant
Not applicable

RATINGS SUMMARY 2016 – 2018

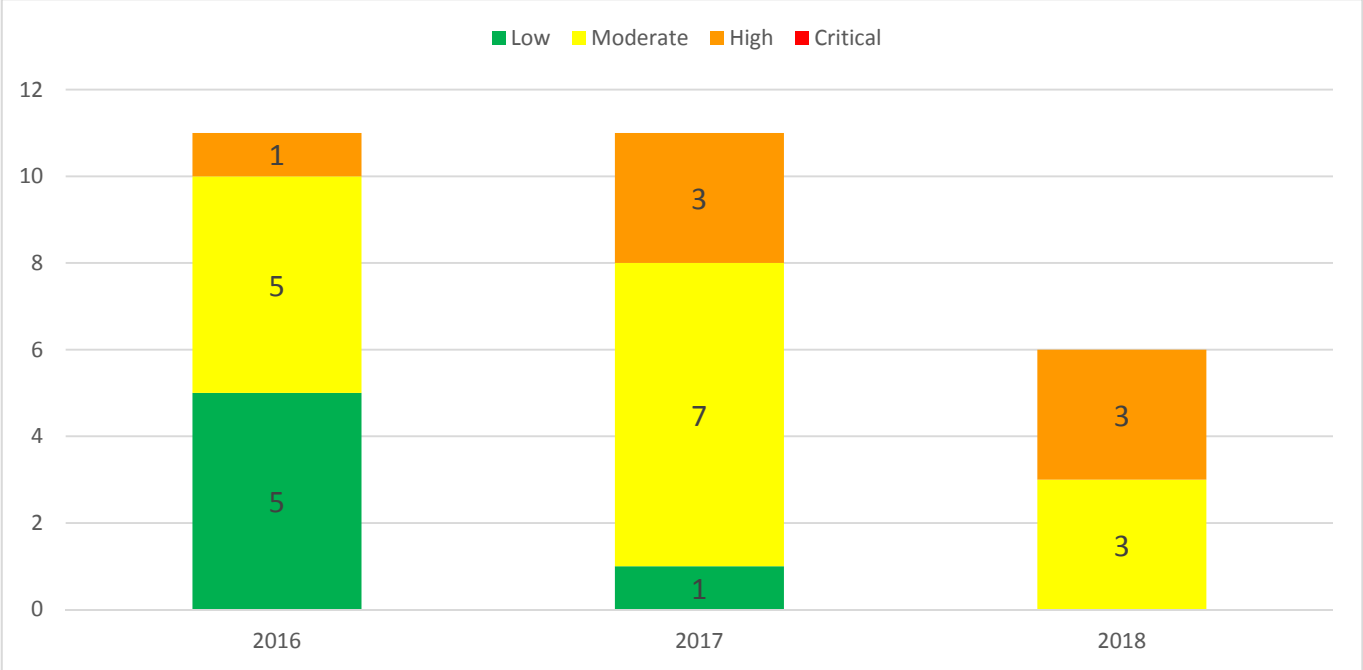
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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 2016 – 2018



Contents

1.0 Introduction to the Inspection Process

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

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

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

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

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

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

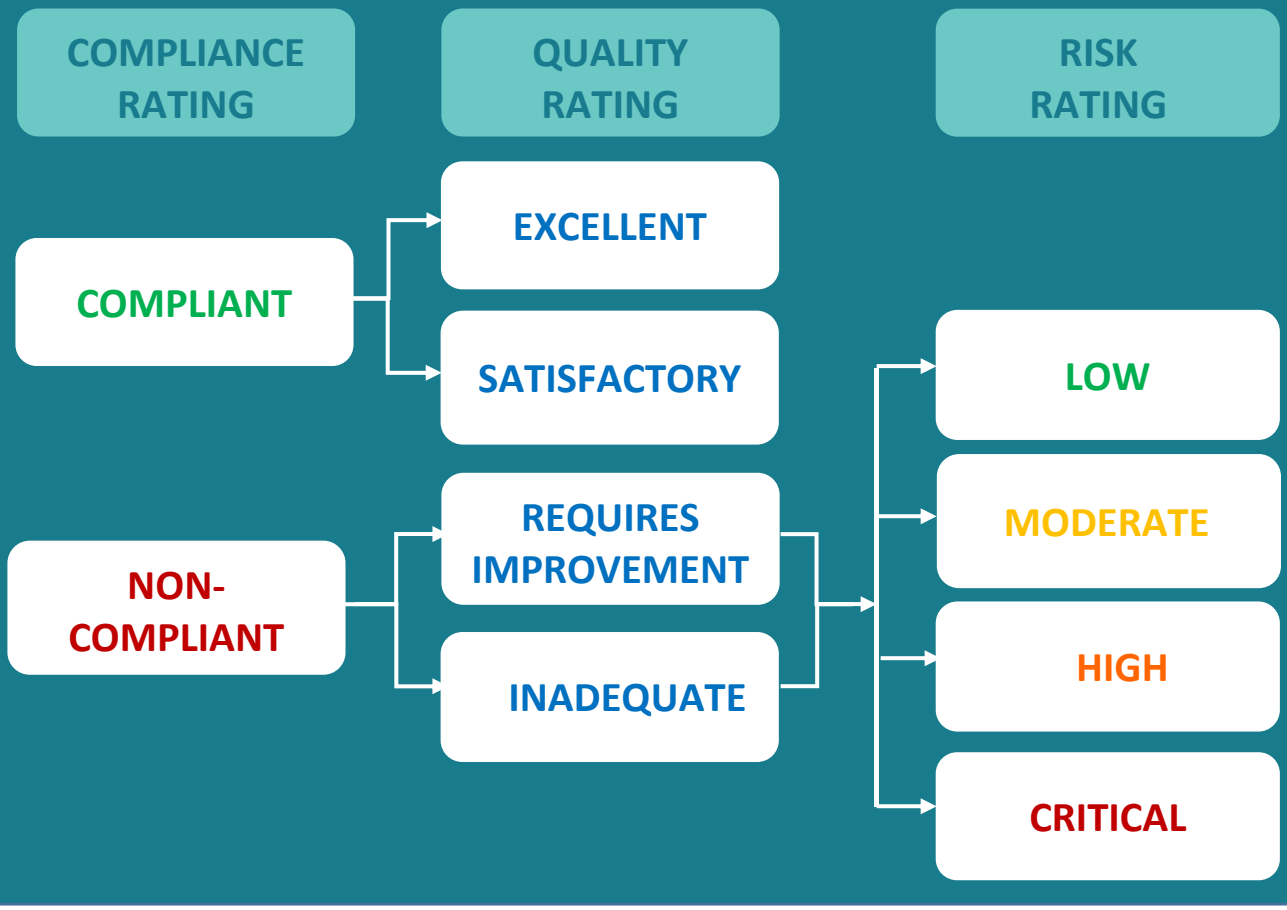
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly,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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, 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 – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The Ashlin Centre was a 44-bed unit located in the grounds of Beaumont Hospital and provided acute in-patient services for the North Dublin Mental Health Service. It consisted of the Joyce Unit, a 38-bed facility for general adult admissions, and the adjoining Sheehan Unit, a six-bed Psychiatry of Old Age (POA) assessment facility.

Compliance with rules, regulations and codes of practice has improved from 70% compliance in 2016 to 84% compliance in 2018. Five regulations had a quality rating of excellent. There was one existing condition to registration with regard to auditing their individual care plans on a monthly basis and reporting the audits to the Mental Health Commission.

Safety in the approved centre

All residents had at least two personal identifiers. Food safety audits had been completed periodically. Hygiene was maintained to support food safety requirements in kitchenettes throughout the approved centre, with the exception of the kitchenette in the Sheehan ward, which had layers of dust on the shelf units. There were some deficits in the prescribing and administration of medication and the stock level of a controlled drug was not accurately recorded in the controlled drug log. Not all staff had up-to-date mandatory training in fire safety, and the management of aggression and violence.

Appropriate care and treatment of residents

There was a comprehensive multi-disciplinary individual care plan (ICP) for each resident, into which each resident had input. There was an extensive range of therapeutic activities which were linked to the resident's care plan. Some residents who were in hospital for more than six months did not receive an adequate physical examination and tests. The approved centre was not compliant with Part 4 of the Mental Health Act 2001.

Respect for residents' privacy, dignity and autonomy

Each resident wore their own clothes and were only in nightclothes if indicated in their ICP. Residents' property was safely stored and residents had access to their property. An area was available where residents could meet with visitors in private. Residents also had access to private means of external communication. Searches were implemented with due regard to the residents' dignity, privacy and gender, and the resident was informed by those implementing the search of what was happening during a search and why. While privacy was respected in most areas, a noticeboard displaying residents' details could be seen by people in a corridor. The use of CCTV respected residents' privacy and dignity. The approved centre was compliant with Rules Governing the use of Seclusion but was non-compliant with the Code of Practice on Physical Restraint.

Residents in Joyce unit who were not in the high dependency unit had to leave the bedroom area during the day to attend activities in the day area. The day area was also where residents had their meals and the bedroom area was locked from mid-morning until 5pm. Residents had to ask to go back to their room and with the occasional exception where a resident was unwell; this was applied to all the residents in Joyce Unit.

Responsiveness to residents' needs

Although residents were provided with nutritious food, a systematic review of menu plans had not been undertaken since 2016. The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and weekends. Communal areas and spaces were suitable for recreational activities. There were small outdoor garden areas for outdoor exercise such as walking. It was not possible for residents to use some exercise equipment, as two of the three pieces of gym equipment, including a cross trainer and bicycle, were broken at the time of the inspection. Remote controls for TVs were also broken. TVs in each room were positioned high up, which made it difficult for residents to turn on and turn off TV, and to change the channels manually. Information about the approved centre as well as written information about a resident's diagnosis and medication was made available to residents. The premises was clean and well maintained and there was a programme of maintenance.

Governance of the approved centre

North Dublin Mental Health Service (NDMHS) was part of the Community Healthcare Organisation (CHO) 9 area. The senior management team of NDMHS was responsible for the management of the Ashlin Centre. The Management Team reported to the Executive Management Team for CHO9. The inspection team were provided with minutes of both the Management Team meetings, which occurred every one to two weeks, and of the Quality and Patient Safety Committee meetings, which occurred every one to two months. These indicated a robust consideration of governance issues pertinent to the operation of the Ashlin Centre.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. New Transfer and Discharge forms.
2. New General Health Assessment form.
3. ICP checklist.
4. Revised Service User Information booklet.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Ashlin Centre was a 44-bed unit located in the grounds of Beaumont Hospital. The approved centre provided for the acute in-patient needs of the North Dublin Mental Health Service (NDMHS). The facility was purpose built and opened in 2014. It was located at ground level and consisted of the Joyce Unit, a 38-bed facility for general adult admissions, and the adjoining Sheehan Unit, a six-bed Psychiatry of Old Age (POA) assessment facility. All accommodation comprised of single bedrooms with en suite facilities. The approved centre had an activities area incorporating an art room, sensory room, activities kitchen, and associated therapeutic rooms. There were also four internal gardens, three serving the Joyce Unit and one for the Sheehan Unit.

The facility served a population of over 250,000 based in the north city and north county areas. There were 11 consultant-led teams, one POA, one rehabilitation, and nine sector teams (two in Balbriggan; two in Swords; two in Kilbarrack; and one in Darndale, Killester, and Coolock).

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**42**
Number of detained patients	17
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	10
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

The following condition was attached to the registration of this approved centre at the time of inspection.

Condition: 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.

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

NDMHS was part of the Community Healthcare Organisation (CHO) 9 area. The senior management team of NDMHS was responsible for the management of the Ashlin Centre. The inspection team were provided with minutes of both the Management Team meetings, which occurred every one to two weeks, and of the Quality and Patient Safety Committee meetings, which occurred every one to two months. The Management Team reported to the Executive Management Team for CHO9.

Minutes of these meetings indicated a robust consideration of governance issues pertinent to the operation of the Ashlin Centre. Staff of the centre were represented on the above committees. In addition, there was a Policy, Procedure, and Protocol Group (PPPG) which met every two months and was tasked with reviewing and updating policies and procedures as required.

As part of the review of governance, the inspection team met with the heads of clinical disciplines:

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

The heads of discipline were able to give a clear overview of management processes and their role in these processes. Supervision and appraisal processes were outlined as they applied to the particular discipline. Specific risks applying currently were outlined. In most disciplines, these risks related to the achievement and maintenance of an adequate staff complement. In addition, the constant high proportion of admissions who were involuntary was perceived as a service risk. Strategic aims over the coming months were the plan to move Sheehan Unit to the first floor (potentially creating extra acute admission beds), and the recruitment of extra dedicated occupational therapist and social work resources to enable expansion of therapeutic services to residents.

4.5 Use of restrictive practices

Residents in Joyce unit who were not in the high dependency unit had to leave the bedroom area during the day to attend activities in the day area. The day area was also where residents had their meals and the bedroom area was locked from mid-morning until 5pm. Residents had to ask to go back to their room and with the occasional exception where a resident was unwell this was applied to all the residents in Joyce Unit.

5.0 Compliance

5.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 19: General Health	✓		✓		✗	High
Regulation 21: Privacy	✗	Moderate	✓		✗	Moderate
Regulation 23: Ordering, Prescribing, Storing & Administration of Medicines	✓		✓		✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate
Mental Health Act Part 4 (2001) Consent to Treatment	✓		✗	High	✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✗	Moderate	✗	Moderate

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.

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 8: Residents' Personal Property & Possessions
Regulation 11: Visits
Regulation 12: Communication
Regulation 29: Operating Policies & Procedures

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

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 Area Lead from the HSE Mental Health Engagement Office was contacted.

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.

Nine residents chose to meet with the inspection team. In addition, one completed resident questionnaire was returned to the inspection team. Feedback from residents was generally positive. Residents were complimentary of the support they received from staff. Food was positively regarded, as was the range of activities available. No matter raised required an immediate action by management or staff. Residents were aware of their clinical teams and were familiar with their key worker.

7.0 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:

- Registered Proprietor
- Executive Clinical Director
- Clinical Director
- Acting Area Director of Nursing
- Service Manager
- Area Lead for Mental Health Engagement
- Nursing Practice Development Co-ordinator
- Occupational Therapy Manager
- Acting Principal Social Worker
- Principal Psychologist
- Pharmacist
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x 3
- Mental Health Act Administrator

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. Clarifications were received regarding various issues that had arisen during the course of this inspection, and these are incorporated into this report.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: A minimum of two person-specific resident identifiers, appropriate to the resident group profile, individual residents' needs, and communication abilities were used. The identifiers, detailed in residents' clinical files, were checked when staff administered medications, undertook medical investigations, or provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre used the name, date of birth, and hospital number of each resident as identifiers. There was a red sticker alert system in place on clinical files to help staff in distinguishing between residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: A systematic review of menu plans had not been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. The most recent menu review was completed in 2016. Documented analysis had not been completed to identify opportunities for improving the processes for food and nutrition

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Vegetarian meal options were consistently available. Residents had at least two choices for meals. Food, including modified consistency diets, was presented attractively.

Hot meals were provided daily at lunchtime, and teatime meals arrived cold and were re-heated. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Hot and cold drinks were offered to residents regularly, until 9:30pm. No current resident had special dietary requirements, however all residents received an evidence-based nutrition screening assessment on admission.

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 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(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 written policy in relation to food safety, which was last reviewed in March 2018. The policy included the requirements of the *Judgement Support Framework,* with the following exceptions:

- Food preparation, handling, storage, distribution, and disposal controls.
- The management of catering and food safety equipment.
- Adhering to the relevant food safety legislative requirements.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was suitable and sufficient catering equipment, and residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements in kitchenettes throughout the approved centre, with the exception of the kitchenette in the Sheehan Ward which had layers of dust on the shelf units which were hard to reach.

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 evidence of implementation pillars.

Regulation 7: Clothing

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in January 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. No current residents were prescribed to wear night clothes during the day.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with appropriate emergency personal clothing which accounted for their preferences, dignity, bodily integrity, religious, and cultural practices. Residents had an adequate supply of individualised clothing.

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 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions, which was last reviewed in January 2017. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. 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 in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept distinct from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre's policy.

Secure facilities, including a safe within one of the approved centre's offices, were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained. This was counter-signed by the resident or their representative, where possible.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in October 2016. The policy included all the requirements of the *Judgement Support Framework* with the exception of the facilities available for recreational activities, including the identification of suitable locations for recreational activities within and external to the approved centre.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents were involved in developing recreational activities.

Timetables were displayed to residents on notice boards throughout the approved centre, detailed accessible and user-friendly information on recreational activities, including the type and frequency of recreational activities. Activities included table tennis, television, games, reading, knitting, art, and crochet. Communal areas and spaces were suitable for recreational activities. Recreational spaces included pool rooms, table tennis rooms, and recreational rooms. There were small outdoor garden areas for outdoor exercise such as walking.

It was not possible for residents to use some exercise equipment, as two of the three pieces of gym equipment including a cross trainer and bicycle were broken at the time of the inspection. Remote controls for televisions (TV's) were broken. TV's in each room were positioned high up, which made it difficult for residents to turn on and turn off TV, and to change the channels manually.

Documented records of attendance were retained for recreational activities in group records or within the resident's clinical file, as 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 evidence of implementation pillars.

Regulation 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents. The policy was last reviewed in January 2017. The policy included the requirements of the *Judgement Support Framework* with the exception of identifying residents' religious beliefs, and the staff roles and responsibilities in relation to supporting residents' religious practices.

Training and Education: Relevant staff had signed the signature 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 to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Residents had access to multi-faith chaplains, and a Eucharistic Minister visited weekly. Residents could be escorted to local religious services such as Beaumont Church, if they desired. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: There were no restrictions on residents' rights to receive visitors in place at the time of the inspection. A documented analysis was completed to identify opportunities to improve visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. It was possible for visits to take place in the tribunal room.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room, areas, and facilities available was suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

(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 policies and procedures in relation to resident communication, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. 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. Documented analysis had been completed to identify ways of improving communication processes; no recommendations for improvements in processes were identified.

Evidence of Implementation: Residents could use mail, fax, telephone, and internet if they wished, unless otherwise risk assessed with due regard to the residents' well-being, safety, and health. At the time of the inspection, no resident was assessed as at risk in relation to their communications. Therefore, no resident communication was being examined by the clinical director or a designated senior staff member.

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches, which was last reviewed in May 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

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

Monitoring: A log of all searches was not maintained, as one search which took place was not recorded. Each search record was not systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis was not completed to identify opportunities for improvement of search processes.

Evidence of Implementation: There had been no environmental searches in the approved centre since the last inspection. One clinical file was inspected. Risk had been assessed prior to the search of the resident and their belongings in the search, and the resident's consent was sought and documented.
The resident search policy and procedure was communicated to all residents. The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted.

Searches were implemented with due regard to the residents' dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. All searches were documented in the clinical file and related National Incident management System (NIMS) form.

A written record of every search of a resident and every property search was available, which included 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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

(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 two separate written operational policies in relation to care of the dying, the care of the dying policy, and the sudden and explained death of service user policy. Both policies were last reviewed in March 2018. The policies included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

Monitoring: Systems analysis had been undertaken in the event of a sudden or explained death in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: There was one sudden death of a resident in the approved centre since the last inspection. The death of the resident was managed in accordance with legal requirements. The resident's religious and cultural practices were respected, and the resident's death was handled with dignity and propriety. The needs of the resident's family were supported. The death was reported to the Mental Health Commission within the required 48-hour timeframe.

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 training and education pillar.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in October 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Residents' ICPs were audited on a monthly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Each resident had an Individual Care Plan (ICP), eleven of which were inspected. All ICPs inspected were a composite set of documentation. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. Residents had been assessed at admission by the admitting clinician and an initial ICP was completed by the admitting clinician to address the immediate needs of residents.

A key worker was identified to ensure continuity in the implementation of residents ICPs. All residents received an evidenced-based comprehensive assessment within seven days of admission. All ICPs identified the resident's assessed needs, documented a set of appropriate goals for each resident, specified the treatment and care required, and identified necessary resources. All ICPs were developed, regularly reviewed, and updated by the resident's multi-disciplinary team.

The ICP was discussed and, where practicable, drawn up, and agreed with the participation of the resident. However, in ten ICPs family input was not evident. Four ICPs did not have a risk management plan, but did have a basic risk assessment recorded. One ICP did not include a preliminary discharge plan. Six residents did not sign their ICP. Five residents were not offered a copy of their ICP, including any reviews, and the explanation for this was not consistently 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 training and education and evidence of implementation pillars.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in January 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre were monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents.

The programmes and services appeared to be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, but care plans did not specifically prescribe programmes that residents should engage in. Instead phrases such as 'encourage to attend activities' were detailed in care plans.

A list of all therapeutic services and programmes provided in the approved centre was available to all residents. Programmes included Wellness Recovery Action Plan (WRAP), mindfulness, a recovery discussion group, anxiety management, self-esteem, and creative expression run by an art teacher once a week. Various workshops were facilitated, such as resilience, diet, bone health, and alcohol education. The activities co-ordinator was a 'hearing voices' facilitator. A social worker was on site two days a week and an occupational therapist five days a week. The Sheehan Ward had ear acupuncture and reminiscence therapy.

Where a resident required a therapeutic service or programme that was not provided internally such as dietetics and chiropody, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies. The Sheehan ward, however, had limited space for therapy sessions, but it was possible to run one-to-one sessions in single bedrooms and in the multi-disciplinary room. A record was 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 training and education pillars.

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, which was last reviewed in January 2016. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. A new transfer log and checklist form had been developed since the last inspection. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical files of two residents who had been transferred from the approved centre, one of which was an emergency transfer was examined. Communication records with the receiving facilities, and their agreement to receive each resident in advance of the transfer were documented. Verbal communication and liaison took place between the approved centre and the receiving facilities in advance of the transfers taking place. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and each resident's accompaniment requirements on transfer.

Both residents were risk assessed prior to the transfer, and documented consent of the resident to their transfer was available. The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, and the resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents' clinical files.

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 training and education pillars.

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two separate written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. Both policies were last reviewed in January 2017. The policies and procedures included the requirements of the *Judgement Support Framework*, with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents' take-up of national screening programmes was not recorded or monitored. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes, which resulted in a recent introduction of a new six-monthly physical assessment template.

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

The five clinical files inspected showed that residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, and the five files inspected showed that all residents had received a six-monthly general health assessment.

While three of the five six-monthly general health assessments were completed adequately, two were not. Specifically, two six-monthly general health assessments inspected did not document Body Mass Index, weight, waist circumference, nutritional status, diet and physical activity, including sedentary lifestyle, and dental health, as required.

There were three residents on antipsychotic medication at the time of the inspection. There was a new template in place in the approved centre for the purpose of documenting all physical assessments and reviews. The template was not adequately or consistently completed. In one case, it was indicated that the resident's blood lipids were ordered, but this did not correspond to the hospital recording system which showed no bloods were ordered. In a second case, the blood lipids and electrocardiogram sections were blank on the annual assessment template.

In three cases, the annual assessment was not detailed on the annual assessment template; it was detailed on a different document. In these three cases, there was no evidence to indicate that each resident's glucose regulation, blood lipids, electrocardiogram, and prolactin were tested.

Adequate arrangements were in place for residents to access general health services and to be referred to other health services. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing such as lab results. Residents had access to national screening programmes appropriate to age and gender. Information was provided to residents regarding national screening programmes available through the approved centre.

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

(a) Two general health assessments did not fulfil the complete criteria stipulated by the Mental Health Commission. 19 (1) (b)

(b) Three annual assessments in relation to three residents on antipsychotic medication did not fulfil the criteria stipulated by the Mental Health Commission. 19 (1) (b)

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

(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 operational policy and procedures in relation to the provision of information to residents, which was last reviewed in January 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for managing the provision of information to residents' representatives, family, and next of kin, as appropriate.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with the approved centre's information booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details. The booklet was available in the required formats to support resident needs and the information was clearly and simply written, but it did not contain information on residents' rights. Residents were provided with details of their multi-disciplinary team (MDT).

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. At the time of the inspection, there were no restrictions on information regarding a resident's diagnosis applied to any resident.

Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. Patients who had medication queries were directed to the pharmacist to receive advice in person.

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 processes, training and education, and monitoring pillars.

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in October 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the staff roles and responsibilities for the provision of resident privacy and dignity.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: The general demeanour of staff and the way in which staff interacted with residents was respectful.

Residents were dressed appropriately to ensure their privacy and dignity, and some residents wore hospital night clothes. All bathrooms, showers, and toilets, and bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards positioned in the nursing office on the Sheehan unit displayed identifiable resident information, and it was possible to see the noticeboard from the corridor. Residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because resident's privacy was not appropriately respected at all times. The noticeboards positioned in the Sheehan unit's nursing office displayed identifiable resident information, and it was possible to see the noticeboard from the corridor.

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in August 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities for the maintenance of the approved centre's premises and related processes.
- The legislative requirements to which the approved centre premises must conform.
- The approved centre's utility controls and requirements.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed separate hygiene and ligature audits. The Queensland tool was used to audit ligatures. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. It was clean, hygienic and free from offensive odours. Accommodation for each resident assured their comfort and privacy and met their assessed needs. All bedrooms were appropriately sized for residents' needs, and all residents had their own single room with en suite facilities. There were adequate and suitable furnishings to ensure residents comfort.

Rooms were not centrally heated, instead rooms had underfloor heating. Heating was controllable from the main reception area, but not in the resident's own room. While there was a sufficient number of toilets

and showers for residents in the approved centre, toilets were located at the end of the corridor, which was a far distance from the dining room.

Sufficient spaces were provided for residents including indoor and outdoor spaces. Internal corridors and communal rooms were spacious by design. There were five outdoor gardens, one of which was for the residents of Sheehan unit. Hazards were minimised in the approved centre. Appropriate signage and sensory aids were provided to support resident orientation needs. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. Remote or isolated areas of the approved centre were monitored, and a local generator provided back-up power to 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, training and education, and evidence of implementation pillars.

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

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication; the policy was last reviewed in January 2016. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for self-administration of medication.
- The process for medication reconciliation.

Training and Education: Not all nursing, medical, and pharmacy staff had signed the signature log to indicate that they had read and understood the policies. All nursing, medical staff, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Nursing and medical staff as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and ten of these were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, and details of route, dosage, and frequency of medication. However, two MPARs did not detail the records of all medications administered and there was no associated explanation in both cases.

The Medical Council Registration Number of every medical practitioner prescribing the medication to each resident were included on each MPAR. The signature of the medical practitioner/nurse prescriber for each entry was detailed in each MPAR entry. A record was kept when medication was refused by or withheld from the resident. Two MPARs did not detail start dates for each medication. An incorrect discontinuation date for some medications was evidenced in a number of MPARs.

Not all entries in MPARs were clearly legible. All entries in each MPAR were written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration and expired medications were not administered. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition. This was documented in the resident's clinical file.

All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Controlled drugs were not accurately checked by two staff members against the delivery form, and details were not entered in the controlled drug book. While there was an adequate amount of controlled drugs in stock, residents brought in an additional supply of their own which totalled approximately 300mls. The residents own supply was not added into the approved centre's total supply of controlled drugs, which meant there was an oversupply on-site. As a result, the controlled drug stock balance did not correspond with the balance recorded in the controlled drug book.

The use of appropriate resident identifiers and good hand-hygiene techniques, and cross-infection control techniques were observed during the administration of medication. Medication was stored in the appropriate and secure environment. Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. Food and drink was not stored in areas used for the storage of medication. An inventory of medications was conducted on a monthly basis, checking the name and dose of medication, quantity of medication, and expiry date. Medications that were no longer required or expired were separated from other medication and returned to the pharmacy for disposal.

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

a) **Two MPARs did not detail the records of all medications administered, and there was no associated explanation in both cases.**
b) **Two MPARs did not detail start dates for each medication.**
c) **An incorrect discontinuation date for some medications was evidenced in a number of MPARs.**
d) **Not all entries in MPARs were clearly legible.**
e) **The stock level of a controlled drug was not accurately recorded in the controlled drug log.**

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had an operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in January 2016. The policy addressed all the requirements of the *Judgement Support Framework* with the exception of details of the specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. Not all staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

COMPLIANT

Quality Rating **Satisfactory**

(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: The approved centre had a written operational policy and procedures in relation to the use of CCTV. The policy addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the use of CCTV as set out in the policy.

Monitoring: CCTV equipment was checked regularly to ensure it was operating appropriately, and this was documented. Analysis was not completed to identify opportunities for improvement of the use of CCTV.

Evidence of Implementation: CCTV was used to observe residents in a seclusion context only. CCTV was clearly labelled and evident, and it was incapable of recording or storing a resident's image on tape, disc, or hard drive. A resident was monitored solely for the purpose of ensuring his/her health, safety, and welfare. The Mental Health Commission had been informed about the approved centre's use of CCTV. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. CCTV cameras transmitted images to a monitor which was viewed solely by the health professional responsible for the resident.

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 monitoring pillar.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 written policy and procedures in relation to its staffing requirements. The policy was last reviewed in May 2018. The policy and procedures addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- Staff performance and evaluation requirements.
- The required qualifications of training personnel.
- The ongoing staff training requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the 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 were reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place which showed the leadership and management structure and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the national HSE policy and procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times, and this was documented.

Opportunities were made available to staff by the approved centre for further education, and these opportunities were effectively communicated to all relevant staff. There were support mechanisms in place including tuition support, scheduled time away from work, or recognition for achievement.

The number and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was available within the approved centre. Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff were trained in recovery-centred approaches to mental health care and treatment, manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management and treatment, incident reporting, and the protection of children and vulnerable adults.

All health care staff were trained in Basic Life Support and the Mental Health Act 2001. Not all health care staff were trained in fire safety, and the Professional Management of Aggression and Violence, and Children First, to enable them to provide care and treatment in line with best contemporary practice. All staff training was documented and staff training logs were maintained.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Joyce	CNM3	1(shared)	1 (shared)
	CNM2	2(1 Activities)	-
	RPN	6	3
	HCA	3(1 Activities)	1
	Occupational Therapist	1	
	Social Worker	0.4	
	Psychologist	-	

Ward or Unit	*Staff Grade*	*Day*	*Night*
Sheehan	CNM3	1(shared)	1 (shared)
	CNM2	1	-
	CNM1	1	
	RPN	1	1
	HCA	1	1
	Occupational Therapist	0.4	
	Social Worker	-	
	Psychologist		

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

The approved centre was non-compliant with this regulation because not all staff had up-to-date mandatory training in fire safety, and the Professional Management of Aggression and Violence, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in June 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for making a retrospective entry in residents' records.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to 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 had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided. Records were maintained in good order overall. Resident records were physically stored together.

Residents' records were secure, up to date, constructed, maintained, and used in accordance with national guidelines and legislative requirements. Records were developed and maintained in a logical sequence. There were two appropriate resident identifiers recorded on all documentation.

Only authorised staff made entries in residents' records, or specific sections therein. Hand-written records were legible and written in black indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases.

Each entry on residents' records did not consistently record the time using the 24-hour clock. Each entry was not consistently followed by a signature. Some retrospective entries appeared to have different hand writing than the original entries.

In cases where errors were made on residents' records, some overwriting was evidenced. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

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 processes, training and education, monitoring, and evidence of implementation pillars.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented up-to-date electronic register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006.

The approved centre was compliant with section 2 of this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in January 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, and were all communicated to all relevant staff.

The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

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 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

(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.

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals, which was last reviewed in January 2016. The policy and procedures included the requirements of the *Judgement Support Framework* with the exception of the provision of information to the patient regarding the Mental Health Tribunals.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend their Mental Health Tribunal as required.

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* under the processes pillar.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

(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 and procedures in place in relation to the management of complaints, which was last reviewed in April 2018. The approved centre also used the HSE's *Your Service, Your* Say complaints policy and process, which was last reviewed in 2017. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policies.

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data were analysed for senior management to consider. Details of the analysis were considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with complaints. A consistent and standardised approach had been implemented for the management of all complaints. Complaints were addressed locally by nurses, and escalated to the Assistant Director of Nursing where necessary. The complaints procedure, including how to contact the nominated person was publicly displayed, and was detailed within the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

All complaints were handled promptly, appropriately, and sensitively. 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 being made.

All complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the compliant.

All information obtained through the course of the management of the complaint, and the associated investigation process, was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. The complainant's satisfaction or dissatisfaction with the investigation findings 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 training and education pillar.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in May 2018. The policy addressed the requirements of the *Judgement Support Framework*, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The policy did not detail the process for maintaining and reviewing the risk register.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The audit measured actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk, the risk advisor, was identified and known by all staff. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of resident seclusion, physical restraint, and at admission, at resident transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were effectively mitigated.

The requirements for the protection of children and vulnerable adults were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator, 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 and training and education pillar.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by 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

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently in the reception area.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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 in relation to the use of seclusion, dated January 2017. It addressed all of the elements of this rule, including the following:

- Those authorised to carry out seclusion.
- The provision of information to the patient.
- Ways of reducing seclusion rates.

Training and Education: All staff involved in the use of seclusion had signed the signature sheet, indicating that they had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: The clinical files of two residents who had been placed in seclusion were inspected. In both cases, seclusion was initiated by a registered medical practitioner and/or registered nurse. The consultant psychiatrist was notified of the use of seclusion as soon as was practicable, and this was recorded in clinical files. Where seclusion was initiated by a registered nurse, an assessment, including a risk assessment, was completed prior to seclusion taking place. The episodes of seclusion were recorded in the clinical files and seclusion register by the registered medical practitioner. The seclusion register was signed by the responsible consultant psychiatrist within 24 hours.

Residents in seclusion had access to adequate toilet or washing facilities. Seclusion facilities were furnished, maintained, and cleaned to ensure respect for residents' dignity and privacy. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

In each episode, seclusion was used only in rare and exceptional circumstances, in the best interests of each resident, and after all other interventions to manage patients' unsafe behaviour had first been considered. Cultural awareness and gender sensitivity were exhibited in each episode of seclusion. In both cases, the implementation and use of CCTV to monitor patients in seclusion was appropriate, and viewing of CCTV was restricted to designated personnel. Patients were informed of the reasons for, duration of,

and circumstances leading to the discontinuation of seclusion, and next of kin were informed in both cases. Next of kin were not informed in both cases and the reasons for this were documented in both clinical files.

In each episode of seclusion, a registered nurse directly observed the patients for the first hour. A record of the patients in seclusion was made by the nurse every 15 minutes, and the resident's level of distress and behaviour were documented. Nursing reviews and medical reviews in relation to seclusion took place, and were completed within the stipulated timeframe by registered medical practitioners.

All uses of seclusion were clearly recorded in the clinical files and on the seclusion register. In all episodes of seclusion inspected, patients were informed of the ending of seclusion and the reasons for ending seclusion were recorded in the clinical files. Each episode of seclusion was reviewed by the multi-disciplinary team (MDT), and documented in the clinical file within two working days after the episode of seclusion.

The approved centre was compliant with this rule.

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating HIGH

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 clinical files of two detained (i.e. involuntary) patients who had been in the approved centre for more than three months, and who had been in continuous receipt of medication for over three months were examined. The two patients were treated as being unable to consent to receiving treatment, but in both cases there was not documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent. This matter was resolved during the course of the inspection.

In both cases a Form 17, Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed. Each Form 17 included details of the discussions with the patient on the nature and purpose of medications. Any views expressed by the patients were recorded. In each case, authorisation was provided by a second consultant psychiatrist.

The following discrepancies were found on inspection:

- One Form 17 did not include the names of the medications prescribed to the patient.
- In both Form 17s confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications was not documented.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment for the following reasons:

a) **For two patients there was not documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent.**
b) **One Form 17 did not include the names of the medications prescribed to the patient.**

11.0 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.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in March 2018. The policy detailed the provision of information to the resident and identified those who can initiate and implement physical restraint. The policy did not address child protection processes where a child was physically restrained.

Training and Education: Not all staff involved in physical restraint had signed the policy log to indicate that they had read and understood the policy.

Monitoring: The approved centre forwarded the relevant annual report to the MHC.

Evidence of Implementation: The files of three residents who had been physically restrained were reviewed. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the three residents. Staff had first considered all other interventions to manage the resident's unsafe behaviour. The restraint order lasted for a maximum of 30 minutes.

The registered medical practitioner completed a physical examination of two residents within three hours after the start of the episode of physical restraint. The third resident was not examined physically after the start of the episode of physical restraint and the explanation for this was documented. The consultant psychiatrist was notified of the episode of physical restraint taking place in all three cases.

The residents were informed of the reasons for, duration of, and circumstances leading to the discontinuation of physical restraint. The residents' next of kin was informed about the physical restraint in all three cases. Cultural awareness and gender sensitivity was demonstrated in each of the three episodes of physical restraint. The episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode. One resident discussed the episode with members of the MDT as soon as was practicable, the other two residents did not and explanations for this were documented. All uses of physical restraint were clearly recorded in the clinical practice forms detailed and recorded within clinical files.

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

a) **The policy did not address child protection processes where a child was physically restrained, 11.2.**
b) **Not all staff involved in physical restraint had signed the policy log to indicate that they had read and understood the policy, 9.2 (b).**

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Training and Education: Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies,

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

Evidence of Implementation: The admission, transfer, and discharge processes were compliant under Regulation 32: Risk Management Procedures, which is associated with this code of practice.

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental health illness or mental disorder. The decision to admit was made by the registered medical practitioner/Consultant Psychiatrist. The resident was assigned a key-worker. The resident's family member/carer/advocate were involved in the admission process, with the resident's consent. The resident underwent an admission assessment which addressed the presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and other relevant information, including work situation, education, and dietary requirement. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team (MDT), and the resident's family. A comprehensive pre-discharge assessment was completed; which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan.

There was appropriate -MDT input into discharge planning. A preliminary discharge summary was sent to the general practitioner/primary care/CMHT within three days. A comprehensive discharge summary was issued within 14 days to the general practitioner/primary care/CMHT, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse. A timely follow up appointment with the resident following discharge was documented.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 19: General Health

Report reference: Page 32 - 33

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. Two general health assessments did not fulfil the complete criteria stipulated by the Mental Health Commission. 19(1)(b)	*New*	Corrective Action(s): Arrange for general health assessments to be undertaken for the relevant residents that fulfil the criteria stipulated by the MHC Post-Holder(s) responsible: Clinical director and ADON	Audit and action plans have been developed to ensure that general health assessments fulfil the criteria stipulated by the MHC Clinical director and ADON are post holders responsible.	Achieveable and realistic	Completed June 2018
		Preventative Action(s): Roll out training for staff regarding the new physical health template which includes all criteria stipulated by MHC. Post-Holder(s) responsible:	Monthly audit and action plans have been developed. Clinical director and ADON are post holders responsible.	Achieveable and realistic.	This commenced in July 2018 and is on-going and continuous

[1] Area of non-compliance reoccurring from 2017
[2] Area of non-compliance not reoccurring from 2017

		Clinical director and ADON			
2. Three annual assessments in relation to three residents on antipsychotic medication did not fulfil the criteria stipulated by the Mental Health Commission. 19(1)(b)	*New*	Corrective Action(s): Arrange for assessments for the relevant residents that fulfil the criteria stipulated by the MHC Post-Holder(s) responsible: Clinical director and ADON	Audit and action plans have been developed. Clinical director and ADON are post holders responsible.	Achieveable and realistic.	Completed June 2018 Monthly Audits commenced July 2018
		Preventative Action(s): Audit and action plans have been developed. Training on use of new physical health assessment tool which includes all criteria stipulated by MHC has been commenced for all relevant disciplines Post-Holder(s) responsible: Clinical director and ADON	Audit and action plans	Achieveable and realistic.	This has commenced July 2018 and audits are completed monthly.

Regulation 21: Privacy

Report reference: Page 36

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
3. Resident's privacy was not appropriately respected at all times. The noticeboards positioned in the Sheehan unit's nursing office displayed identifiable resident information, and it was possible to see the noticeboard from the corridor.	*New*	Corrective Action(s): Install privacy board Post-Holder(s) responsible:	Audit	Achieved.	Completed June 2018
		Preventative Action(s): Privacy board in place Post-Holder(s) responsible: Clinical director and ADON		Achieved.	Completed June 2018

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

Report reference: Page 39 - 40

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
4. Two MPARs did not detail the records of all medications administered, and there was no associated explanation in both cases. 5. Two MPARs did not detail start dates for each medication. 6. An incorrect discontinuation date for some medications was evidenced in a number of MPARs.	*New*	Corrective Action(s): Document administration of medication in both cases Post-Holder(s) responsible: CNM2	Nursing Metrics audit tool	Achieveable and realistic	Completed June 2018
		Preventative Action(s): Introduce medication management training and audits. Post-Holder(s) responsible: Clinical Director and ADON	Nursing Metrics audit tool	Achieveable and realistic	Training and monthly audits are on-going since July 2018
7. Not all entries in MPARs were clearly legible	*New*	Corrective Action(s): Rewrite MPARS of current residents as indicated Post-Holder(s) responsible: Responsible Prescribing Physician	Medication audits	Achieveable and realistic.	Completed June 2018
		Preventative Action(s): Introduce training for medical staff and audit MPARs.	Medication audits Audit of training records	Achieveable and realistic.	Training and monthly auditing commenced in June 2018 and is on-going

		Post-Holder(s) responsible: Clinical Director			
8. The stock level of a controlled drug was not accurately recorded in the controlled drug log.	*New*	Corrective Action(s): The stock level of the relevant controlled drug is now accurately recorded. Post-Holder(s) responsible: CNM2	Medication audit	Achieved.	Completed June 2018
		Preventative Action(s): Education with nursing staff has been carried out Post-Holder(s) responsible: Pharmacist and CNM2	Nursing metrics	Achievable	Training commenced July 2018

Regulation 26: Staffing

Report reference: Page 43 - 44

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
9. Not all staff had up-to-date mandatory training in fire safety, and the Professional Management of Aggression and Violence, 26(4).	Reoccurring	Corrective Action(s): 1. Fire training dates are available for all disciplines annually 2. A Schedule of dates annually for TMVA training are available for all disciplines 3. A temporary CNM2 post has been deployed as assistant education coordinator for Nursing . Post-Holder(s) responsible: Heads of disciplines	Monitoring function is part of the TOR for the MDT training committee. Annual training analysis Monitored by each head of discipline	Achievable	1.Commenced July 2018 and ongoing 2. Commenced September 2018 and ongoing 3.CNM2 in post since October 2018
		Preventative Action(s): 1.Fire training dates are available for all disciplines annually 2. A Schedule of dates annually for TMVA training are available for all disciplines	Monitoring function is part of the TOR for the MDT training committee Annual training analysis	Achievable	1.Commenced July 2018 and ongoing 2. Commenced September 2018 and ongoing

		3. A temporary CNM2 post has been deployed as assistant education coordinator for Nursing . Post-Holder(s) responsible: Heads of disciplines	Monitored by each head of discipline		3.CNM2 in post since October 2018

Part 4: Consent to Treatment

Report reference: Page 60 - 61

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
10. For two patients there was not documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent.	Reoccurring	Corrective Action(s): A capacity assessment was completed for the two residents . Post-Holder(s) responsible: Responsible Consultant	Audit	Achieved.	Completed June 2018.
		Preventative Action(s): A new template for consent to treatment has been developed to include evidence that a capacity assessment has taken place. Training will be provided for consultants Post-Holder(s) responsible:Clinical Director	Monthly audit	Achievable	Template developed October 2018 Training commenced November 2018 and ongoing
11. One Form 17 did not include the names of the medications prescribed to the patient.	Reoccurring	Corrective Action(s): The relevant form has been re-designed Post-Holder(s) responsible:	Audit	Achieved	Completed June 2018

		Responsible Consultant			
		Preventative Action(s): Inform staff of New Form Audit Post-Holder(s) responsible: Clinical Director	Audit.	Achievable	Monthly audit commenced October 2018

Code of Practice: Use of Physical Restraint

Report reference: Page 63

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
12. The policy did not address child protection processes where a child was physically restrained, 11.2.	New	Corrective Action(s): The existing policy has been updated and includes child protection processes. All staff will become familiar with the HSE Child Protection and Welfare Practice Handbook(2016) Post-Holder(s) responsible:Heads of Discipline/PPPG committee	Action is completed Audit staff training data base	Achieved	Achieved November 2018
		Preventative Action(s): All policies will be reviewed annually and updated on a three yearly basis or more often if required. Post-Holder(s) responsible: PPPG committee	Ongoing monitoring through audit and follow up recommendations and actions	Achievable	Annual review 1st quarter every year
13. Not all staff involved in physical restraint had signed the policy log to	Reoccurring	Corrective Action(s):	On-going monitoring through audit and follow up	Achieved	Achieved November 2018

indicate that they had read and understood the policy, 9.2 (b).		All staff involved in physical restraint will sign the policy log to indicate that they had read and understood the revised policy. Post-Holder(s) responsible: Heads of Discipline	recommendations and actions		
		Preventative Action(s): All new staff to the unit will be inducted on operational policy development Post-Holder(s) responsible: Heads of Discipline	Ongoing monitoring through audit	Achievable	Commenced July 2018 and ongoing