Central Mental Hospital

ID Number: AC0048

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Central Mental Hospital
Dundrum
Dublin 14

Approved Centre Type:
Forensic Mental Health Care

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Pauline Gill, General Manager, National Forensic Mental Health Services

Inspection Team:
Mary Connellan, Lead Inspector
Carol Brennan-Forsyth
Leon Donovan
Martin McMenamin
Siobhán Dinan
Karen McCrohan

Inspection Date:
26 – 29 June 2018

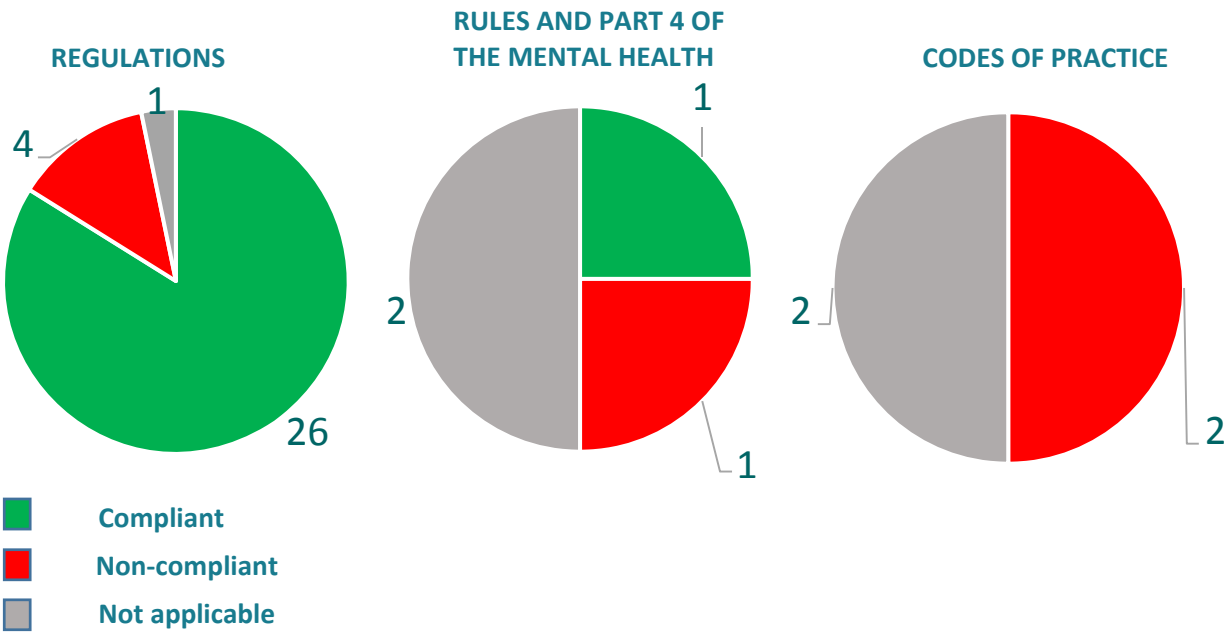
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
11 – 14 July 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
7 February 2019

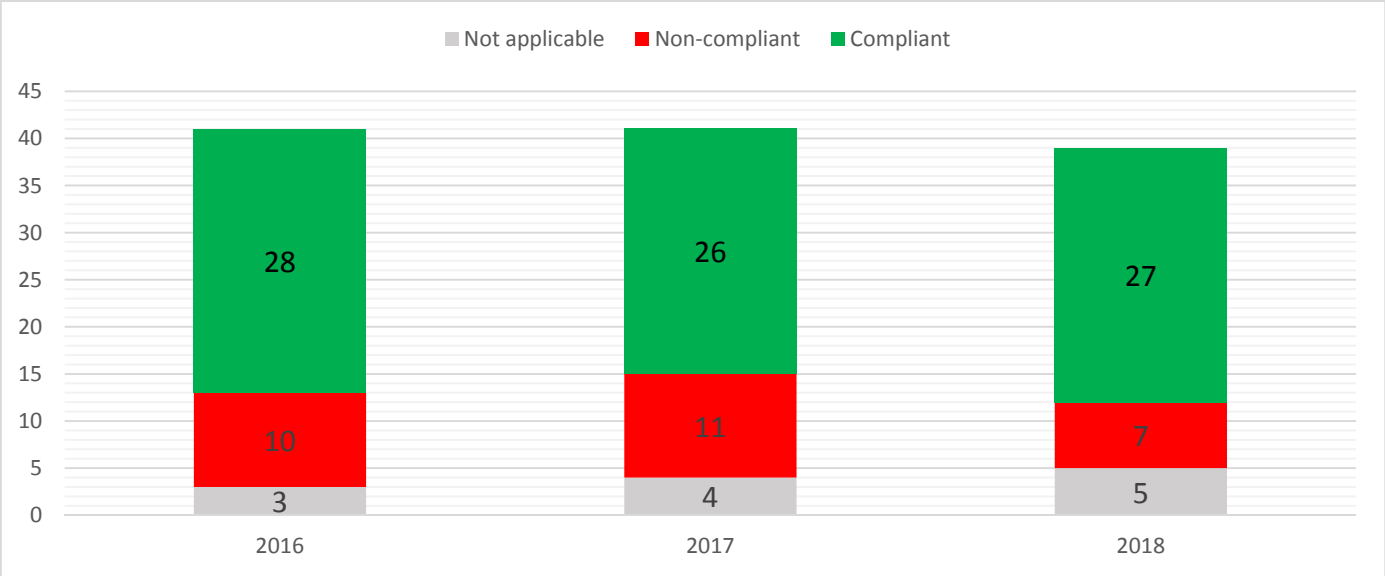
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

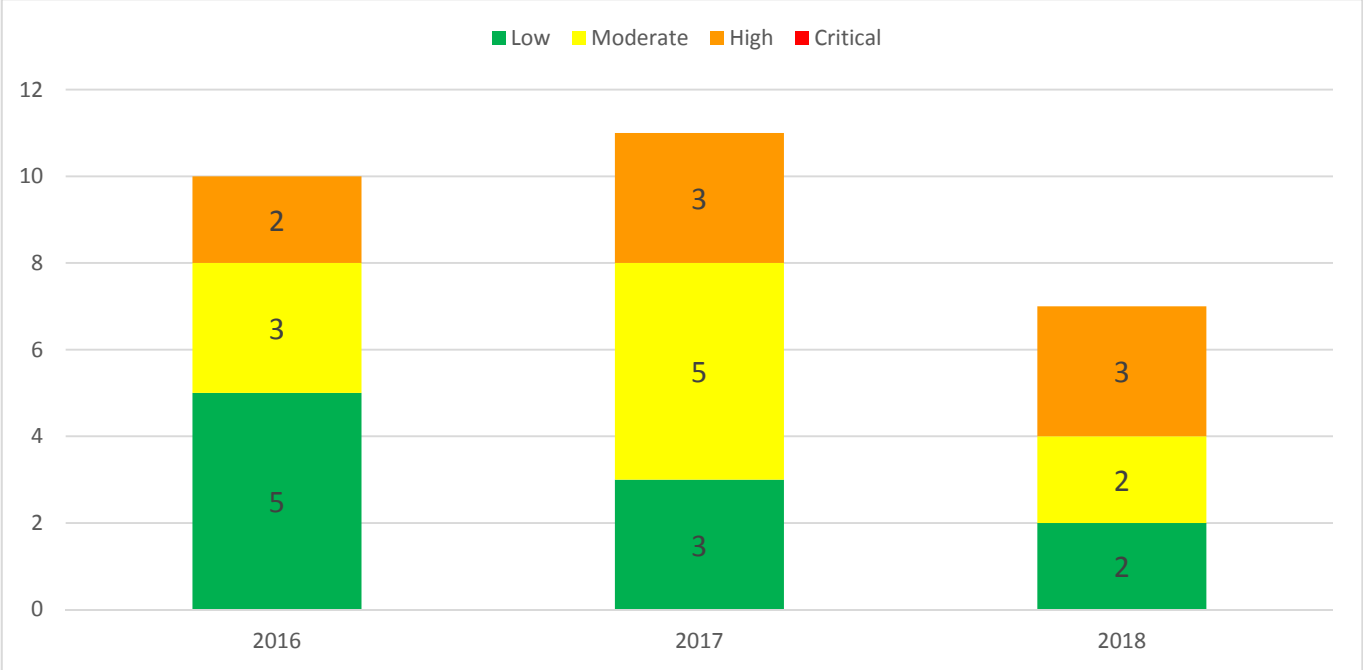
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 resident 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.

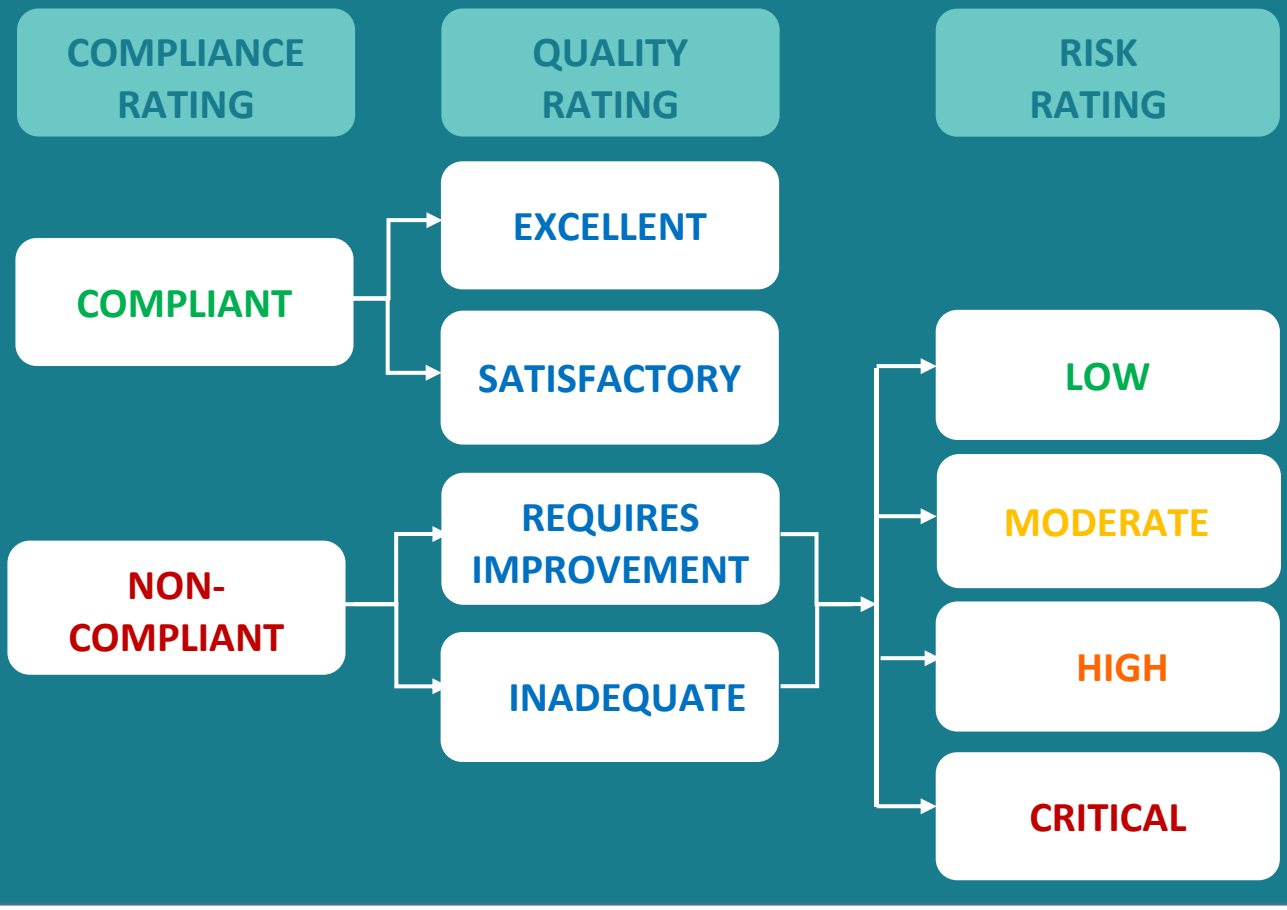
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, 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 Central Mental Hospital, Dundrum, Dublin was part of the National Forensic Mental Health Service. The main building dated back to 1852. While efforts had been made to refurbish and maintain the buildings, they were not fit for purpose and the Mental Health Commission had a condition attached to the approved centre's registration with regard to closure. A new premises was in construction phase in Portrane, Co Dublin, due to open in 2020.

The male patients progressed through a secure therapeutic care pathway which was sub-divided into three clusters; acute, medium, and rehabilitation and recovery. One unit provided care and treatment for those patients with a dual diagnosis of mental illness with intellectual disability. There was only one unit for the care and treatment of up to ten female patients. The level of security in the one female unit included high, medium, and low, which was not in keeping with best practice or the model of care afforded to the male population. There were waiting lists for people in prison with severe mental illness (26) and also in a number of acute approved centres around the country (6), where their forensic treatment needs were not being met.

Compliance with regulations, rules and codes of practice had improved from 70% in 2017 to 79% in 2018. There were no compliances rated as excellent quality on this inspection.

Safety in the approved centre

Each patient had two personal identifiers for receiving treatments. Food safety audits had been completed periodically but food temperatures had not been recorded in one unit in line with food safety recommendations.

The seclusion rooms were designed with furniture and fittings which posed a potential risk to patient safety. There was no soft padding in the seclusion room, and the observation window frame was designed with metal edges in two seclusion rooms inspected.

The oven in Unit 7, where patients prepared food and used the oven on a regular basis, was noted to be very dirty during the walkabout on the first day of inspection. This was subsequently remedied. Not all health care staff were trained in fire safety, Basic Life Support, management of aggression and violence, the Mental Health Act 2001 and Children First.

Appropriate care and treatment of residents

Each patient had a multi-disciplinary individual care plan into which they had input. These were regularly reviewed. There was a wide range of evidence-based therapeutic programmes based on each patient's needs.

Menus in the approved centre were not approved by a dietitian to ensure nutritional adequacy in accordance with patients' needs. An evidence based nutrition assessment tool was not routinely used for patients with special dietary requirements.

Registered medical practitioners assessed patients' general health needs on admission and on an ongoing basis as part of the approved centre's provision of care. Primary health care staff had launched a pilot research project to address the on-going issues of effective and efficient weight management among patients in the approved centre.

The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist at all in two cases; in a third case it was signed by the consultant psychiatrist but not within the stipulated 24-hour timeframe.

The approved centre had established the 'Recovery College' and 'Involvement Centre' and two peer educators had been employed. There were enhanced education opportunities for the service users and enhanced work opportunities in collaboration with Employability Ireland. A 'Recovery Principles & Practices Workshop' (RPPW) programme had been established.

Respect for residents' privacy, dignity and autonomy

There were facilities for visiting, which were private insofar as the security requirements allowed. External communication was monitored only if stated in the individual care plan as per security requirements. Patients wore their own clothes and had access to their property. Valuables were stored appropriately. Searches were carried out in a manner that respected dignity.

Patients were confined to their bedrooms which were locked at nine o'clock each evening until the morning, regardless of their risk status. Blanket restrictions applied to all female patients on Unit 1 regardless of what stage of the treatment process they were engaged in.

Responsiveness to residents' needs

Some patients praised the food and recent changes to include the provision of an evening snack and the calorie count of each meal. Patients chose from the four week rotating menus and could request certain

foods by filing in a dietary requisition form. The evening tea, in particular the quality of the salads, was criticised by a number of patients.

There was a wide range of recreational activities during the week and at weekends.

The approved centre was not clean, which has been a recurring problem on previous inspections. The approved centre was in a poor state of repair and not appropriate for the care of patients. This will, however, be addressed with the completion of the new premises.

Adequate information was provided to the patients about the approved centre, their diagnosis and about the medication they were prescribed. There was a complaints procedure in place which met the requirements of the regulation.

Governance of the approved centre

The approved centre was part of the National Forensic Mental Health Service, and the Senior Management Team (SMT) reported directly to the Mental Health Division of the HSE.

The SMT comprised of the general manager who was the registered proprietor, the executive clinical director, the area director of nursing, the principal social worker, the occupational therapy manager, the senior clinical psychologist, and an administrator. The team met weekly and minutes reviewed evidenced a thorough and robust agenda with identified actions. The SMT also conducted quarterly walkabouts in the approved centre; actions arising with persons responsible were documented.

On the week of the inspection, most SMT members were transitioning to the new Portrane Hospital management team and a new operational management team was being formed specifically for the approved centre. A quality and risk advisor had been appointed and commenced employment within the approved centre a month prior to the inspection.

The approved centre provided very specific training on individual risk assessment and management for all staff. There was a risk register which was reviewed quarterly.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. With the provision of the Service Reform Fund the approved centre had established the 'Recovery College' and 'Involvement Centre'. In collaboration with Mental Health Ireland two peer educators had been employed. There were enhanced education opportunities for the service users and enhanced work opportunities in collaboration with Employability Ireland.

2. A 'Recovery Principles & Practices Workshop' (RPPW) programme had been established. Two facilitation teams which comprised of three persons; a family member, a service user, and a staff member had been convened and trained. The RPPW programme was piloted and evaluated externally with identified recommendations before it was rolled out within the service.

3. A research study on Metabolic Syndrome and Diabetes had commenced.

4. A reflective practice group, which included nursing, occupational therapy, and social work, had been established.

5. The catering department had devised a survey that was going to be given to each of the patients for completion. This followed on from a meeting the catering manager had with the patients.

6. A Quality and Risk Advisor had been appointed to the approved centre and had commenced employment a month prior to the inspection.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Central Mental Hospital, which was part of the National Forensic Mental Health Service, was situated in the urban location of Dundrum, Dublin. It extended over 34 acres of mature, well-tended, and manicured gardens. It comprised of a number of buildings, mainly Victorian and dating back to 1852. The most recent building on the campus dated back to 1970. While efforts had been made to refurbish and maintain the buildings, they were not fit for purpose and the Mental Health Commission had a condition attached to the approved centre's registration for its closure.

The approved centre was comprised of nine separate units and each had a distinct function in the pathway that was provided for individual care and treatment. Known as 'Pillars of Care' there were seven identified pillars that formed part of the therapeutic programme provided for the patients. Typically, the male population progressed through a series of units which were sub divided into three clusters; acute, medium and rehabilitation and recovery. One unit provided care and treatment for those patients with a dual diagnosis of mental illness with intellectual disability. There was one unit for the care and treatment of up to ten female patients. Therefore, the level of security in the female unit included high, medium, and low needs which was not in keeping with best practice or the model of care afforded to the male population. There were seven in-patient teams in the approved centre.

As well as the in-patient beds at the Central Mental Hospital, the National Forensic Mental Health Service included day centre and out-patient clinics, four community residences, and a prison in-reach service to all the national prisons including Oberstown young offenders centre and the Court diversion service. Referrals to the approved centre were usually made by the National Forensic Mental Health Service and other approved centres throughout the country. There were eleven consultant forensic psychiatrists nationally all whom were part of the on call rota for the approved centre.

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

Resident Profile	
Number of registered beds	***103***
Total number of patients	**96**
Number of detained patients	96
Number of wards of court	1
Number of children	0
Number of patients in the approved centre for more than 6 months	90
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Condition 1: The approved centre shall submit a plan to the Mental Health Commission for the closure of the approved centre, including the transfer or discharge of all current residents. The approved centre shall provide updates on the closure plan in a form and frequency prescribed by the Commission. The updates shall include the ongoing programme of maintenance for the approved centre, up until all residents have been transferred or discharged.

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

Encompassing the approved centre and the wider National Forensic Mental Health Service, the Senior Management Team (SMT) reported directly to the Mental Health Division of the HSE.

The SMT comprised of the general manager who was the registered proprietor, the executive clinical director, the area director of nursing, the principal social worker, the occupational therapy manager, the senior clinical psychologist, and an administrator. The team met weekly and minutes reviewed evidenced a thorough and robust agenda with identified actions. The SMT also conducted quarterly walkabouts in the approved centre; actions arising with persons responsible were documented.

Other regular meetings included a Risk and Seclusion Monitoring and Review Group, Health and Safety Committee, and a Policy Procedure Protocol and Guidance Committee.

On the week of the inspection, most SMT members were transitioning to the new Portrane Hospital management team and a new operational management team was being formed specifically for the approved centre. A quality and risk advisor had been appointed and commenced employment within the approved centre a month prior to the inspection.

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

- Executive Clinical Director National Forensic Mental Health Service and Clinical Director of the Approved Centre
- Area Director of Nursing
- Interim Director of Nursing
- Interim Principal Social Worker
- Senior Occupational Therapist representing the Occupational Therapy Manager
- Senior Clinical Psychology Manager

Responsibilities were clearly defined within the organisation, along with escalation processes for the respective professional groupings. Heads of discipline had received training on clinical risk management,

National Incident Management and health and safety. The approved centre provided very specific training on individual risk assessment and management for all staff.

With the exception of nursing and psychology, the heads of discipline stated that they were adequately resourced. There were approximately twenty nursing vacancies and the approved centre was actively recruiting nursing staff which was an ongoing challenge particularly in the wider Dublin area.

Not every team had a clinical psychologist attached. There were 3.6 Whole Time Equivalent psychologists and up to six voluntary assistant psychologists. While the latter's contribution was greatly acknowledged by the management the overall number of clinical psychologists attached to the approved centre were considered insufficient given the specific treatment protocols and needs of the patients. It was stated that the patients had to wait longer than was clinically advised to progress from one care pillar to another, most notably to pillar four. It was understood that a further two psychology posts were being progressed through the National Recruitment System.

Another challenge identified was the lack of capacity to accommodate all the individuals that required treatment in the approved centre. The inspection team were informed that there were six residents in approved centres throughout the country that required the services of a specialist forensic team. There were also 26 individuals in prison that were on the waiting list for admission to the approved centre. It was reported that some patients were not able to progress through their care pathway as quickly as their care plan indicated because there was no space in the unit required for the next phase of treatment.

Supervision was offered and provided to all the professional groups.

4.5 Use of restrictive practices

All the female patients in Unit 1 were confined to their bedrooms from 9pm each evening irrespective of the stage of the care pathway the patient was at. This was because all female patients were accommodated in the one unit.

Patients in unit one reported that they did not get to go outside as often as they liked and time outside of the unit was restricted. Patients stated that they understood this to be due in the main to staffing constraints.

As outlined in the patient personal property and possessions policy no patient was permitted to have their mobile phone or personal monies on their person.

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 6: Food Safety	✗	High	✗	High	✗	High
Regulation 21: Privacy	✗	Moderate	✓		✗	High
Regulation 22: Premises	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate
Rules Governing the Use Of Seclusion	✓		✗	Low	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✗	Moderate	✗	Low
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Low

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

No areas of compliance were rated excellent on this inspection.

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 did not admit children, 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 no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Residents	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 patients in a number of different ways:

- Posters were displayed inviting the patients to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting patients to talk to the inspection team.
- Set times and a private room were available to talk to patients.
- In order to facilitate patients who were reluctant to talk directly with the inspection team, patients 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.
- A representative from the Irish Advocacy Network met with a member of the inspection team.

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

The inspection team met with twenty patients. Overall, patient feedback was very positive. Some patients praised the food and recent changes to include the provision of an evening snack and the calorie count of each meal. The evening tea in particular the quality of the salads was criticised by a number of patients. It was also noted that porridge was not available on a Sunday.

Demand and supply for activities namely; art, garden project (at times), gym, and education and training was raised by a number of patients. The inspection team was told that a patient could be months waiting for access to these. One person stated it is 'purely a capacity issue'. The enjoyment and benefits of the activities and education and training was commented on positively by those who attended them.

Availability of toilets was remarked by one gentleman and the fact that there is no bench or chair in the male showers. The completion of the refurbishment and upgrading of bathroom and toilet facilities was praised.

Nineteen completed service user questionnaires were returned to the inspection team. All indicated that patient understood their care plan and knew who their key worker was. It was reported that patients knew their respective sector multi-disciplinary team and patients stated they met with team members two to three times weekly. The patients stated that they were always involved with setting their goals for their individual care plan. Eight completed questionnaires indicated that the patient felt there was not enough activities. One wrote that there was 'a very long waiting list' for the Vocational Educational Programme.

Patients indicated that they could communicate freely with family/friends or advocates. Most stated that they always felt able to give feedback to staff and to make a complaint, with two indicating 'sometimes' to this question. On a scale of 1-10 with 1 being poor and 10 being excellent, most patients rated 8, 9 or 10 for

their overall experience of care and treatment. Comments on these questionnaires were that it ‘takes a long time to fix things’, that ‘the library needed improvement’, and that ‘the staff were excellent’.

The Irish Advocacy Network provided a full time advocacy service to the patients in the approved centre with an advocate available Monday to Friday. The advocate also attended the Residence Forum Meetings that were held six-weekly. The inspection team was advised that the advocate would visit each unit three or four times weekly. Feedback from patients to the advocate was extremely positive and any issues raised had been discussed or included in the questionnaires by the patients themselves. The advocate did say that patients reported that the complaints process functioned very well and that there were good relations between the patients, the management, and the carers group.

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 and General Manager
- Executive Clinical Director/Clinical Director and Consultant Forensic Psychiatrist
- Interim Director of Nursing
- Senior Occupational Therapist representing the Occupational Therapy Manager
- Interim Principal Social Worker
- Senior Psychologist representing the Psychology Manager
- Consultant Forensic Psychiatrist x 4
- Catering Officer
- Non Consultant Hospital Doctor/Senior Registrar
- Head of Maintenance
- Quality and Safety Advisor
- Mental Health Act Administrator x 2

Apologies were received on behalf of the Senior Psychology Manager and the Area Director of Nursing.

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. Where applicable, this is reflected in the corresponding regulations, rules, and codes of practice in the report. It was acknowledged that irrespective of the legal status of the patient, consent processes were applied equally to all patients by the approved centre.

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 **Satisfactory**

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 patients, which was last reviewed in 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities in relation to the identification of patients.
- The process for identifying patients with the same or a similar name.

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 identifying patients, as set out in the policy.

Monitoring: An annual audit had not been undertaken to ensure that there were appropriate patient identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the patient identification process.

Evidence of Implementation: Arrangements were in place in the approved centre to ensure that each patient was readily identifiable by staff. Two person-specific identifiers were used by the approved centre. Name, date of birth, and photograph were on all clinical files. An appropriate patient identifier was used prior to the administration of medication, the undertaking of medical investigations, and the provision of health care services. An appropriate identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for patients with the same or a similar name.

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

Regulation 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 February 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. 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 been undertaken to ensure that patients were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Patients chose from the four week rotating menus and could request certain foods by filing in a dietary requisition form. Patients were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot and cold drinks were offered to patients regularly. A source of safe, fresh drinking water was available to patients at all times in easily accessible locations in the approved centre.

Menus in the approved centre were not approved by a dietitian to ensure nutritional adequacy in accordance with patients' needs. An evidence based nutrition assessment tool was not routinely used for patients with special dietary requirements. Patients, their representatives, family, and next of kin were educated about patients' diets, where appropriate.

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

Regulation 6: Food Safety

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 February 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. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date training in food safety commensurate with their role.

Monitoring: Food safety audits had been completed periodically. Food temperatures had not been recorded in one unit in line with food safety recommendations. Food temperature log sheets had been maintained and monitored for all other units. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was suitable and sufficient catering equipment in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Patients were provided with appropriate crockery and cutlery.

Food was prepared in the main hospital kitchen in a manner which reduced the risk of contamination, spoilage, and infection. There was a cleaning schedule in the approved centre, and the catering manager had developed a hygiene inspection checklist. The oven in Unit 7, where patients prepared food and used the oven on a regular basis, was noted to be very dirty during the walkabout on the first day of inspection. This was subsequently remedied.

The approved centre was non-compliant with this regulation because a high standard of hygiene was not maintained in relation to the cooking and serving of food, as evidenced by the dirty oven in Unit 7, 6 (1) (c).

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 clothing, which was last reviewed in February 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the responsibility of the approved centre to provide new clothing to patients, where necessary, with consideration of the patients' preferences, dignity, bodily integrity, and religious and cultural practices.

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 patients' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for patients was monitored on an ongoing basis. No patients were wearing nightclothes at the time of inspection.

Evidence of Implementation: Patients were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Patients changed out of nightclothes during daytime hours unless otherwise specified in their Individual Care Plans. Patients 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 processes and training and education.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to patients' personal property and possessions, which was last reviewed in February 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. Relevant staff interviewed were able to articulate the processes for patients' personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to patients' personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safekeeping of patients' monies, valuables, personal property, and possessions, as necessary. On admission, the approved centre compiled a detailed property checklist with patients of their personal property and possessions. The property checklist was kept separately to the patient's individual care plan (ICP) and was available to the patient. Patients were supported to manage their own property, unless this posed a danger to the patient or others, as indicated in their ICP and in accordance with the approved centre's policy. There were blanket restrictions on mobile phones and monies. However, these restrictions were based on risk and were clearly outlined within the Personal Property Policy.

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 monitoring pillars.

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 2017. 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. 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 patient uptake and attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: Patients in the approved centre had access to a wide range of appropriate recreational activities, which included indoor and outdoor games, walking, guitar, saxophone and ukulele lessons, calypso music groups, rap music lessons, table quizzes, and bingo nights. The approved centre also had a band called Rhythm, which staff and patients were involved in. Patients in each Unit had access to relaxation groups. Access was provided to recreational activities on weekdays and during the weekend. Patient feedback indicated that recreational activities were not always appropriately resourced. Most noted was access to art, the garden project, and the gym.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved did not meet all criteria of the *Judgement Support Framework* under the training and education 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 patients, which was last reviewed in January 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of respecting patients' religious beliefs during the provision of services, care, and treatment.

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 facilitating patients in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support patients' religious practices was reviewed to ensure that it reflected the identified needs of patients. This was documented.

Evidence of Implementation: Patients' rights to practice religion were facilitated within the approved centre insofar as was practicable. There was a church within the hospital grounds, which patients could attend if they had ground leave. The church could be used for mass and other multi-faith services. Care and services that were provided were respectful of the patients' religious beliefs and values and any specific religious requirements were clearly documented. The patients were facilitated to observe or abstain from religious practices 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 and training and education pillars.

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

(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 July 2017. 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. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on patients' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate and reasonable. A separate visitor room or visiting area was provided unless there was an identified risk to the patient or others, or a health and safety risk. Appropriate steps were taken to ensure the safety of patients and visitors during visits. Visiting children were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. There was an identified area for children visiting.

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 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to patient communication, which was last reviewed in February 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities of staff in relation to patient communication processes.

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 communication, as set out in the policy.

Monitoring: Patients' communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Patients had access to mail, e-mail, and telephone unless otherwise risk assessed with due regard to the patients' well-being, safety, and health. Risk assessments had been completed for patients, as deemed appropriate, in relation to any risks associated with their external communication and documented in the individual care plan. The clinical director or senior staff only examined incoming and outgoing patient communication where there was reasonable cause to believe the communication may result in harm to the patient or others. Patient access to the internet was being considered by the approved centre at the time of the inspection

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

Regulation 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 patient searches, which was last reviewed in February 2016. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The management and application of searches of a patient, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a patient 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: 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 searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record had not been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had not been completed to identify ways of improving search processes.

Evidence of Implementation: Patient consent was sought prior to all searches. The request for consent and the received consent were documented for every search of a patient and every property search. General written consent was sought for routine environmental searches. Information around the patient search policy and procedure was communicated to all patients on admission and prior to each search. Patients were informed by those implementing the search of what is happening during a search and why.

A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the patient's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the patient being searched. A written record of every search of a patient and every property search was available, which included the reason the search. A written record was kept of all environmental searches.

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 monitoring pillars.

Regulation 14: Care of the Dying

COMPLIANT

(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 written operational policies and protocols in relation to care of the dying, which were last reviewed in February 2018. The policies and protocols included all 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 policies. All relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policies.

As no patient had received end of life care or had died since the last inspection, the monitoring and evidence of implementation pillars were not applicable.

The approved centre was compliant with this regulation.

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 February 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. All multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Patients' ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Each patient had an ICP, ten of which were inspected. A key worker and a nurse was identified to ensure continuity in the implementation of a patient's ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Patients 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 the patient. All patients received an evidenced-based comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the patient and their representative, and next of kin, as appropriate. Family were involved in patients' ICPs with the patient's consent.

The ICPs identified patients' assessed needs, appropriate goals, the care and treatment required to meet the identified goals including the frequency and staff responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan. None of the ten ICPs inspected included a preliminary discharge plan, which was appropriate to the forensic context of the approved centre.

ICPs were reviewed by the MDT in consultation with patients on a weekly basis. Patients had access to their ICPs and were kept informed of any changes. All patients were offered a copy of their ICP, including any reviews.

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 monitoring 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 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 therapeutic activities and programmes, as set out in the policy.

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

Evidence of Implementation: A range of therapeutic programmes was available to patients. The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the patients, as documented in patients' individual care plans (ICPs). The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of patients. The approved centre provided a Physical Education and Recreation Programme that addressed physical health and social skills.

There were psycho-educational programmes which addressed mental state, psychological functioning, and the individual's insight and awareness into their mental health. There were Cognitive and Behavioural Programmes which covered a wide range of individual and group behavioural and cognitive therapies provided by a range of disciplines and included: Cognitive Remediation Therapy; Cognitive Skills Training; Dialectical Behaviour Therapy; Stress and Anger Management; Substance Misuse; Mental Health; Challenging Behaviour Interventions and Offending Behaviour.

There were Vocational Programmes which addressed the development of occupational skills and the process of recovery through meaningful activities. A Self-Help and Peer Support programme was available, which promoted personal growth through a weekly GROW meeting. Alcoholics Anonymous meetings were held twice weekly within the approved centre. There was also a Friends and Families Information Day held twice yearly. Patients had access to occupational therapy, social work and clinical psychology on an individual basis. It was reported that there has been a delay accessing psychology for some patients. Patients also had access to medical, dental, and chiropody services.

Where a patient required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in

an appropriate location or onsite. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within the patient's progress notes and in formal reports.

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 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 patients, which was last reviewed in February 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities for the patient transfer process, including the responsibility of the multi-disciplinary team and patient's key worker.

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 the transfer of patients, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: Full and complete written information for the patients was transferred when he or she moved from the approved centre to another facility. Information was sent in advance and accompanied the patient upon transfer to a named individual, along with a photocopy of the Medication Prescription and Administration Record (MPAR). A letter of referral, including a list of current medications was issued, with copies retained, as part of the transfer documentation.

A patient transfer form or patient transfer checklist were not used as part of the transfer documentation. The medical team completed a referral letter and this was sent on transfer, along with a photocopy of the patient's MPAR.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(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 written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in February 2018. The medical emergencies policy was last reviewed in January 2017. The policies and procedures combined addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The management, response, and documentation of a medical emergency, including cardiac arrest.
- The resource requirements for general health services, including equipment needs.
- The protection of patient privacy and dignity during general health assessments.
- The referral process for patients' general health needs.

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: Patients' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of patients occurred. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: There was evidence that the policies on the provision of general health services and responding to medical emergencies had been implemented throughout the approved centre. The approved centre had six Automated External Defibrillators on-site. Each unit in the approved centre had access to emergency equipment and medication. Registered medical practitioners assessed patients' general health needs on admission and on an ongoing basis as part of the approved centre's provision of care. Primary health care staff had launched a pilot research project to address the on-going issues of effective and efficient weight management among patients in the approved centre.

Five clinical files were inspected in order to monitor and assess patients' general health needs and specific needs not less than every six months. The six-monthly general health assessment documented the following: a physical examination; family and personal history; body mass index, weight, and waist circumference; blood pressure; smoking status; nutritional status (diet and physical activity, including

sedentary lifestyle tendencies); a medication review, as per prescriber guidelines; dental health. Adequate arrangements were in place for patients to access general health services and for their referral to other health services as required. Patients had access to national screening programmes, available based on age and gender, which included breast check, cervical screening, retina check (for diabetics only), and bowel screening.

The HSE policy on smoking cessation was used and implemented in the approved centre. Staff resources to aid smoking cessation included education programmes and nicotine replacement therapy. A number of patients had been supported to stop smoking.

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

Regulation 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 policy in relation to the provision of information to patients, which was last reviewed in January 2016. The policy included all the requirements of the *Judgement Support Framework*.

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 patients, as set out in the policy.

Monitoring: The provision of information to patients 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 patients.

Evidence of Implementation: Required information was provided to patients and their representatives on admission, including the approved centre's information folder that detailed care and services. The information booklet was available in the required formats to support patient needs and information was clearly and simply written. It contained details of the following: housekeeping arrangements, including procedures for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies; patients' rights. Patients were provided with details of their multi-disciplinary team.

Patients were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the patient's physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a patient's diagnosis was documented in the clinical file. Medication information sheets as well as verbal information were provided in a format appropriate to patient needs. The content of medication information sheets included information on indications for use of all medications to be administered to the patient, including any possible side effects.

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 monitoring pillars.

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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 patient privacy, which was last reviewed in January 2017. The policy did not address the following requirements of the *Judgement Support Framework*:

- The roles and responsibilities for the provision of patient privacy and dignity.
- The method for identifying and ensuring, where possible, the patients' privacy and dignity expectations and preferences.
- The approved centre's process for addressing a situation where patient privacy and dignity is not respected by staff.

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 patient privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to patient privacy. Analysis had been completed to identify opportunities for improving the processes relating to patients' privacy and dignity.

Evidence of Implementation: Patients were accommodated in single bedrooms. Patients were called by their preferred name. The general demeanour of staff and the way in which staff addressed and communicated with patients was respectful. All bathrooms, showers, toilets, and single bedrooms had locks with an override facility. Staff were discreet when discussing the patient's condition or treatment needs. One member of staff in the approved centre was observed wearing a t-shirt and shorts at the time of the inspection.

Rooms were not overlooked by public areas but Units 2, 3 and 5 were missing privacy curtains on the bedroom doors. Noticeboards did not display patient names or other identifiable information. Not all units of the approved centre facilitated patients to make and take private phone calls. The majority of patient phone calls were made and taken in phones located in public areas of the approved centre, which were within audible distance of other patients, as well as staff.

Female patients' dignity was not respected at all times. Blanket restrictions applied to all female patients on Unit 1 regardless of what stage of the treatment process they were at. Patients were confined to their bedrooms which were locked at nine o'clock each evening until the morning, regardless of their risk status.

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

a) **Patient privacy was not respected at all times. There were missing privacy curtains on bedroom doors located in Units 2, 3 and 5.**
b) **Not all patients were facilitated to make and take private phone calls.**
c) **Female patients' dignity was not respected at all times. Blanket restrictions applied to all female patients on Unit 1 regardless of what stage of the care pathway they were at.**

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 residents 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 January 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre's utility controls and requirements.
- The identification of hazards and ligature points in the premises.

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 relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene audit and a ligature audit. The ligature audit was not carried out using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre had appropriately sized day rooms and communal spaces where patients could sit. Rooms were ventilated. The temperature was adequate throughout the approved centre, but heating could not be safely controlled in the patient's own room. There was a sufficient number of showers for patients. There were no signs indicating where toilets were, or to indicate what various rooms in the approved centre were used for. There were enough non-assisted toilets for patients, but there was not an assisted toilet in each unit.

The approved centre did not have any lifts. Unit A did not have a dedicated therapy room. Not all bedrooms were appropriately sized to meet patients' needs. Bedrooms in Units 1, 2, 3, 5 and 7 were too

small. Due to the inadequate storage space in the bedrooms, patients in Unit 7 were required to store their belongings in wardrobes located in corridors. The seclusion room in Unit B was particularly small.

The large day rooms and high ceilings in the old building led to echoes and poor acoustics when patients were trying to watch television. Patients in Units 1, 2, 3 and 5 had no direct access to outdoor areas. Access to the outdoors was dependent on staff availability for escorting the patients, and staff were generally unavailable. Patients were allocated 90 minutes of time to spend on outdoor activities but they indicated that they would prefer longer.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard and rough surfaces were not minimised. To access Unit 3 patients had to climb three flights of stairs. Due to the age of the building there were no lifts installed. There was also a slip hazard on the floor of the laundry room because the tumble drier was leaking, and there were sharp edges in the seclusion room in Unit 1 at the time of the inspection.

Numerous ligature risks were observed during the course of the inspection. These ligature risks were logged in the ligature audit. Ligatures were mitigated by the approved centre, through observation and risk assessments of patients in relation to ligatures.

The approved centre was not kept in a good state of repair externally and internally. Paint was peeling, floors were worn, and there were holes in the walls. There was mould on the silicon in the bathrooms in Laurel Lodge, curtains missing off doors, and a curtain was falling down in Unit 7. A privacy screen on a window in Unit B was peeling, and there was a stain on the floor of the food store.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. However, the approved centre was not clean, hygienic, and free from offensive odours. Cobwebs were present in a bedroom in Unit 1 and a vacated room in Unit 3 was dirty. A thick layer of dust was observed on furniture and on the floor during the inspection time. Remote or isolated areas of the approved centre were monitored.

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

a) **The premises were not clean and in good structural and decorative condition, 22(1)(a):**
   - **A vacated bedroom in Unit 3 was dirty.**
   - **Cobwebs were present in a bedroom in Unit 1**
   - **Mould was identified on the silicon in the bathrooms in Laurel Lodge.**
   - **There was a stain on the floor of the food store.**
   - **There was dust on furniture and on the floors of the approved centre.**
   - **Floors were worn throughout the approved centre.**
   - **There were holes in the walls.**

b) **The condition of the physical structure and the overall approved centre environment was not maintained with due regard to the safety and well-being of patients, 22(3):**
   - **Hazards were not minimised.**
   - **A privacy screen on a window of Unit B was peeling**
   - **Bedrooms in Unit 1, 2, 3, 5, and 7 were not of an adequate size to address patient needs.**
   - **There were sharp edges in the seclusion room of Unit 1.**

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

COMPLIANT

Quality Rating **Satisfactory**

(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 series of written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication. The Rapid Titration Policy was last reviewed in July 2015. The policies combined included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for crushing medications.
- The processes for medication management at admission, transfer, and discharge.
- 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, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policies. Not all staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and 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 patient had an MPAR. Each MPAR evidenced a record of appropriate medication management practices, including a record of two patient identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. One MPAR did not detail the generic name of the medication and preparation. Four MPARs used the abbreviated term for micrograms, MCG, instead of writing the name of it in full. One MPAR did not record the stop date for each medication.

The Medical Council Registration Number of every medical practitioner prescribing medication to the patient was present within each patient's MPAR. The signature of the medical practitioner was present on each MPAR entry. MPARs did not contain dedicated space for once-off medications, instead once-off medications were prescribed and documented in the 'as required' (PRN) medications.

All entries in MPARs were written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the patient's care or condition. This was documented in the clinical file. 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. All medicines were administered by a registered nurse

or registered medical practitioner and any advice provided by the patient's pharmacist regarding the appropriate use of the product was adhered to. Good hand-hygiene techniques were implemented during the dispensing of medications. When a patient's medication was withheld, the justification was not always recorded in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a secured locked room. Refrigerators used for medication were used only for this purpose. There were no temperature probes on the fridges in Unit 1 or Unit 7. Medication storage areas were incorporated in the cleaning and housekeeping schedules.

A monthly system of stock rotation was implemented to avoid the accumulation of old stock. This was done on a monthly basis. An inventory of medications was conducted on a monthly basis, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication. Medications that were no longer required, which were past their expiry date or had been dispensed to a patient but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

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 two written operational policies, and one safety statement in relation to the health and safety of patients, staff, and visitors. The health and safety policy was last reviewed in March 2017. The policy and safety statement combined included all of the requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the health and safety policies. 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 two written policies and protocols in relation to the use of CCTV. The CCTV policy was last reviewed in January 2016. The policies combined included the requirements of the *Judgement Support Framework* with the following exceptions:

- The maintenance of CCTV cameras by the approved centre.
- The process to cease monitoring a patient using CCTV in certain circumstances.

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

Monitoring: The quality of the CCTV images was not checked regularly to ensure that the equipment was operating appropriately. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions indicating where CCTV cameras were located in the approved centre. CCTV cameras used to observe a patient were incapable of recording or storing a patient's image on a tape, disc, and hard drive. CCTV was used solely for the purposes of observing a patient by a health professional who was responsible for the welfare of that patient. CCTV was not used to monitor a patient if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

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

Regulation 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, which was last reviewed in June 2017. The policy also directed the reader to the National Recruitment Service policies. The policy and procedures addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

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

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 was 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 been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of patients.

Evidence of Implementation: There was an organisational chart in place, which identified 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 approved centre's 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 was maintained in the approved centre which showed that an appropriately qualified staff member was on duty and in charge at all times.

Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement.

The number and skill mix of staffing were sufficient to meet patient needs with the exception of psychology. There were not enough psychologists to deliver the planned programmes but there were two additional posts being processed through the National Recruitment Service at the time of the inspection.

A written staffing plan was available within the approved centre. Staff were trained in line with the assessed needs of the patient group profile and of individual patients, as detailed in the staff training plan. Staff were trained in manual handling, infection control and prevention, care for patients with an intellectual disability, risk management and treatment, incident reporting, and the protection of vulnerable adults.

Not all health care staff were trained in the following:

- Fire safety
- Basic Life Support
- Management of Aggression and Violence
- The Mental Health Act 2001
- Children First.

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*
Unit A	CNM2	1	1
	RPN	3	2
	HCA	1	1

Ward or Unit	*Staff Grade*	*Day*	*Night*
Unit B	CNM2	1	0
	RPN	6	3
	HCA	1	0

Ward or Unit	*Staff Grade*	*Day*	*Night*
Unit 1	CNM2	1	0
	RPN	5	3
	HCA	1	0

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the Management of Violence and Aggression, and Children First, 26(4).
b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

Ward or Unit	Staff Grade	Day	Night
Unit 2	CNM2	1	0
	RPN	4	3
	HCA	1	0
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 3	CNM2	1	0
	RPN	4	3
	HCA	1	0
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 5	CNM2	1	
	RPN	5	3
	HCA	1	
Ward or Unit	**Staff Grade**	**Day**	**Night**
Unit 7	CNM2	1	
	RPN	2	2 (3 until 10.30pm)
	HCA	2	
Ward or Unit	**Staff Grade**	**Day**	**Night**
Laurel Lodge	CNM2	1	
	RPN	1	2

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

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 January 2018. The policy included all of the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- General safety and security measures in relation to records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

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. All clinical staff were trained in best-practice record keeping.

Monitoring: Patients' records were not audited to ensure their completeness, accuracy, and ease of retrieval. The records of transferred and discharged patients were not 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: Patients' records were appropriately secured from loss, destruction, tampering, and unauthorised access or use. All patient records were reflective of the patients' status and the care and treatment being provided. Clinical files inspected were in good order. Records were not developed and maintained in a logical sequence, and individual care plans were amalgamated with progress sheets.

Patient records were physically stored together. Patient records were maintained using an identifier, which was unique to the patient. Photographs, dates of birth, and names were used. Only authorised staff made entries in patients' records, or specific sections therein. Hand-written records were legible and written in black indelible ink and were readable when photocopied. All patients' records included the date, and time using the 24-hour clock. 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 rating was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.

Regulation 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, register of patients admitted. The register contained the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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 February 2016. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The process for making obsolete and retaining previous versions of operating policies and procedures.
- The standardised operating policy and procedure layout used by the approved centre.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all 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 not been undertaken to determine compliance with review time frames. Analysis had not 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. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

The format of the operating policies and procedures was not entirely standardised. At the time of the inspection, not all policies had been reformatted to the HSE template, as this process was on-going.
Any generic policies used were appropriate to the approved centre and the patient group profile.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals, which was last reviewed in February 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 and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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 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 relation to the management of complaints, which was last reviewed in January 2016. The approved centre also used the HSE's *Your Service, Your Say* complaints policy. 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 and documented, but there was no evidence that the findings were acted upon. Complaints data was analysed and details of the analysis were considered by senior management. Required actions had not 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 all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed through posters in the visitor areas and it was detailed within the service user's information booklet. Patients, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally and in writing and through feedback forms. Senior management walked through the approved centre on a monthly basis to talk to patients and listen to their concerns.

All complaints were handled promptly, appropriately, and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a patient 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. Minor complaints from patients were sent directly to the complaints officer. If there was a pattern of minor complaints, the senior nurses in the unit were asked to address the issues at community meetings. The complaints officer responded in writing to all patients' complaints.

Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the patient's individual care plan. The complainant's satisfaction or dissatisfaction with the investigation findings was documented.

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.

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 monitoring pillars.

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 February 2018. The policy addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The person responsible for the completion of six-monthly incident summary reports.
- The process for notifying the Mental Health Commission about incidents involving patients of the approved centre.
- The process for the protection of vulnerable adults within the care of the approved centre.

Training and Education: All relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. All clinical staff were trained in individual risk management processes. Management staff 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 was identified and known by all staff, and 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 (MDT) were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of patient seclusion and physical restraint, and at patient admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

Structural risks, including ligature points, remained. Each patient was risk assessed and managed accordingly in relation to ligature risks. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. There was a separate visitor's room for child visitors near the entrance.

Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service.

The Mental Health Act administrator, in line with the Code of Practice on the Notification of Deaths and Incident Reporting, provided a six-monthly summary of incidents to the Mental Health Commission. Information provided was anonymous at patient level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

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 which was prominently displayed in the main reception of the wall. The condition relating to the certificate of registration was documented and prominently displayed.

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

NON-COMPLIANT

Risk Rating MODERATE

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a resident in seclusion or apply mechanical means of bodily restraint to the resident 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 resident 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 resident.
(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 "resident" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary resident.

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, which was reviewed annually, and was last reviewed in February 2018. It included all of the policy criteria of this rule pursuant to Section 69 of the Mental Health Act 2001. The policy addressed who may implement seclusion, the provision of information about seclusion to the patient, and the ways of reducing rates of the use of seclusion.

Training and Education: Not all staff involved in seclusion had signed to indicate that they had read and understood the policies.

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

Evidence of Implementation: The clinical files of three patients who had been in seclusion were inspected. Patients in seclusion had access to adequate toilet and washing facilities. The seclusion rooms were not used as bedrooms, but were designed with furniture and fittings, which posed a potential risk to patient safety. There was no soft padding in the seclusion room, and the observation window frame had metal edges in two seclusion rooms inspected.

In all cases, seclusion was initiated by a registered medical practitioner and/or a 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 a registered nurse initiated seclusion, an assessment, including a risk assessment, was completed prior to seclusion taking place. The seclusion orders were recorded in the clinical files and seclusion register by the registered medical practitioner. The registered medical practitioner indicated the duration of the seclusion order, which was no longer than eight hours.

Seclusion was used only in rare and exceptional circumstances, in the best interests of the patient, and after all other interventions to manage patients' unsafe behaviour had first been considered. Cultural awareness and gender sensitivity were demonstrated in each episode of seclusion. In all 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.

In each episode of seclusion, a registered nurse directly observed the patients for the entire duration of seclusion. A record of the patients in seclusion was made by the nurse every 15 minutes, and the patient'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. Each episode of seclusion was reviewed by the multi-disciplinary team, and documented in the clinical file within two working days of the episode of seclusion.

In two episodes, the seclusion register had not been signed by the responsible consultant psychiatrist or duty consultant psychiatrist. In a third episode the seclusion register was signed by the consultant psychiatrist but not within the stipulated 24-hour timeframe.

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

a) **No written record was available to indicate that staff involved in the use of seclusion had read and understood the policy, 10.2 (b), 10.2 (c).**
b) **The seclusion rooms were designed with furniture and fittings which posed a potential risk to patient safety. There was no soft padding in the seclusion room, and the observation window frame was designed with metal edges in two seclusion rooms inspected.**
c) **The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist at all in two cases; in a third case it was signed by the consultant psychiatrist but not within the stipulated 24-hour timeframe, 3.5.**

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

COMPLIANT

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

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

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

57. - (1) The consent of a resident shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the resident, the treatment is necessary to safeguard the life of the resident, 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 resident 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 resident 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 resident gives his or her consent in writing to the continued administration of that medicine, or

b) where the resident 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 resident, 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 thirty-five patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were inspected. In all cases, there was documented evidence that the consultant psychiatrist had undertaken a capacity assessment, which measured the patients' ability to consent to receiving treatment.

In relation to the patients who did consent to receiving treatment there was a written record of consent which detailed:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of discussions with the patient, including
  - The nature and purpose of the medications.
  - The effects of the medications(s), including any risks and benefits.

Where the patient was unable to give consent, the administration of medication was approved by the responsible consultant psychiatrist and another consultant psychiatrist. The relevant parts of Form 17 (Administration of Medicine for More than 3 Months to an Involuntary Patient (Adult) – Unable to Consent) was completed in full by both consultant psychiatrists.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

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 **LOW**

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 on the use of physical restraint, which was reviewed annually, and was last reviewed in January 2018. The policy addressed the provision of information to patients, those who can initiate and implement physical restraint, and staff training requirements.

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

Monitoring: The approved centre forwarded the annual report on physical restraint to the Mental Health Commission.

Evidence of Implementation: The clinical files of two patients were examined in relation to three episodes of physical restraint. Clinical files indicated that physical restraint was only used in exceptional circumstances when patients posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each patient. Staff had first considered all other interventions to manage patients' unsafe behaviour. In all cases, the physical restraint order lasted less than ten minutes. Physical restraint was not prolonged beyond the period strictly necessary to prevent immediate and serious harm to self or others. In all cases inspected, the registered medical practitioner completed a physical examination of each patient within three hours after the start of an episode of physical restraint.

In two cases, the patients' next of kin or representative was not informed about the physical restraint episode, and the reasons for not informing them were documented in the clinical file. All episodes of physical restraint were reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode. Both patients were given the opportunity to discuss the physical restraint episode with members of the MDT involved in their care as soon as was practicable. In all cases, the clinical practice form was signed by the consultant psychiatrist within 24 hours.

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

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to patient admission, transfer, and discharge. The admission policy was last reviewed in October 2017, the transfer policy was last reviewed in February 2016, and the discharge policy was last reviewed in January 2018. All policies combined included the policy criteria of this code of practice with the exception of the discharge policy; it did not include the procedure for discharging homeless people**.**

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

Monitoring: Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one patient was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The patient was assigned a key worker. The patient was transferred from a prison and their family member was due to be contacted following admission into the approved centre. The patient received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The patient 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 clinical file of one patient who was discharged was inspected. The patient was discharged back to a prison facility. The discharge was co-ordinated by a key worker. A discharge plan was in place as part of the individual care plan. The discharge plan recorded the estimated date of discharge, documented communication with the relevant general practitioner, a follow-up plan, and a reference to early warning signs and risks. A discharge meeting was held and attended by the patient, their key worker, relevant members of the multi-disciplinary team and the patient's family member. A pre-discharge assessment was completed; which addressed the patient's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. A family member was involved in the discharge process.

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

a) **Not all relevant staff had signed to indicate that they had read and understood the admission, transfer, and discharge policies, 9.1.**
b) **The discharge policy did not include the procedure for discharging homeless people, 4.12.**
c) **Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies, 4.19.**

Appendix 1: Corrective and Preventative Action Plan Template - 2018 Inspection Report

Regulation 6: Food Safety

Report reference: Page 18

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. A high standard of hygiene was not maintained in relation to the cooking and serving of food, as evidenced by the dirty oven in Unit 7, 6 (1) (c).	*Reoccurring*	Corrective Action(s): Oven was cleaned immediately and observed by inspectors. Post-Holder(s) responsible: General Management Team has met with managers from external contractors to address issues. Discussed with service users on Unit 7 at walk-around requesting that they could contribute with monitoring. Post-Holder(s) responsible: General Manager Catering Officer	Ovens will be deep cleaned once a week and checked daily and recorded by cleaning staff.	Achievable and Realistic	Immediately completed and ongoing monitoring.
		Preventative Action(s): The service's Operational Management Team (OMT) will conduct a quarterly quality and safety walk-around of all units. Post-Holder(s) responsible: OMT	Any housekeeping matters identified from this process will be notified immediately to the appropriate responsible supervisor/manager for action. Continue with monthly hygiene audits	Achievable and Realistic	Ongoing

Regulation 21: Privacy

Report reference: Page 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
2. Resident privacy was not respected at all times. There were missing privacy curtains on bedroom doors located in Units 2, 3 and 5.	*New*	Corrective Action(s): Curtains have been replaced in all bedrooms identified. Post-Holder(s) responsible: Unit Manager & ADON	Completed	Achievable and Realistic	Completed
		Preventative Action(s): Spare curtains will be maintained in stock to replace immediately when required. Post-Holder(s) responsible: Unit Manager & ADON	Unit Managers will regularly check that curtains are in place via completion of unit checklist. OMT will check privacy curtains are in place on walk-around and document same.	Achievable and Realistic	Ongoing
3. Not all residents were facilitated to make and take private phone calls.	*New*	Corrective Action(s): Privacy hoods will be installed. Privacy Hoods purchased. Post-Holder(s) responsible: General Manager	General Manager to inspect on receipt of completion report from maintenance.	Achievable and Realistic	January 2019
		Preventative Action(s): Where risked assessed as safe portable phones will be used for patients calls in a designated private area. Post-Holder(s) responsible: Unit Manager & ADON	Unit Managers will oversee the provision of this facility to ensure privacy for patients.	Achievable and Realistic	Ongoing

4. Female residents' dignity was not respected at all times. Blanket restrictions applied to all female residents on Unit 1 regardless of what stage of the care pathway they were at.	*New*	Corrective Action(s): The service's Operational Management Team (OMT) and Clinical Teams will assess and review all blanket restrictions placed on female residents with a view to ensuring that any restrictions are in response to an assessed risk and in line with least restrictive practice/response. An environmental review will be undertaken to explore options for: • The facilitation of stratification of residents' care pathway. • Increasing access to the unit's garden area. The design of the female service in the new build allows for a coherent pathway for female patients due to open in 2020. Post-Holder(s) responsible: OMT MDTs General Manager	A restrictive practice baseline audit will be completed for each female resident of Unit 1.	Achievable and Realistic	End of Quarter 1 2019
		Preventative Action(s): The remedial actions will be monitored by the service's OMT Post-Holder(s) responsible: OMT	CAPA completion will be monitored through the OMT's governance meetings.	Achievable and Realistic	Ongoing

Regulation 22: Premises

Report reference: Pages 38 & 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
5. The premises were not clean and in good structural and decorative condition, 22(1)(a): • A vacated bedroom in Unit 3 was dirty. • Cobwebs were present in a bedroom in Unit 1 • Mould was identified on the silicon in the bathrooms in Laurel Lodge. • There was a stain on the floor of the food store. • There was dust on furniture and on the floors of the approved centre. • Floors were worn throughout the approved centre. • There were holes in the walls.	*Reoccurring* *Monitor as per condition*[1]				
6. The condition of the physical structure and the overall approved centre environment was not maintained with due regard to the safety and well-being of residents, 22(3): • Hazards were not minimised. • A privacy screen on a window of Unit B was peeling • Bedrooms in Unit 1, 2, 3, 5, and 7 were not of an adequate size to address resident needs. • There were sharp edges in the seclusion room of Unit 1.					

[1] To ensure adherence to *Regulation 21: Privacy* and *Regulation 22: Premises*, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

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Regulation 26: Staffing

Report reference: Pages 44-46

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
7. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the Management of Violence and Aggression, and Children First, 26(4). 8. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccurring*	Corrective Action(s): 1. Increase percentage of compliance. 2. Provide additional opportunities to access online training. 3. Provision of protected time and facilities to allow online training. Post-Holder(s) responsible: CNM3 Allocations Officers Nurse Practice Development Officer Ward Managers Heads of Disciplines	The introduction of the Matrix System in the Allocations Office allows the service to monitor the nursing training record A HR Manager has been appointed and will hold a Centralised record of all training recorded and submitted by each line manager.	Achievable and Realistic	Review in 3 months, March 2019, provided up to date percentage of compliance.
		Preventative Action(s): Additional PC's have been provided in non-clinical areas for the provision of access to online training. Post-Holder(s) responsible: Line Managers	Monthly audit of training records. All Line Managers will maintain a record of all training in their area of responsibility and submit to HR Manager. Centralised record of all training to be held by HR Manager	Achievable and Realistic	Review in 3 months, March 2019, provided up to date percentage of compliance.

Section 69: The Use of Seclusion

Report reference: Pages 59 – 60

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. No written record was available to indicate that staff involved in the use of seclusion had read and understood the policy, 10.2 (b), 10.2 (c).	*Reoccurring*	Corrective Action(s): All managers have been tasked with ensuring that all relevant staff have read and understood the seclusion policy and signed the appropriate log. A unit based quick reference policy folder and signature log will be held on each unit. Post-Holder(s) responsible: Unit Managers, Discipline Leads Line Manager	Monthly audit of unit policy signature log specific to unit.	Achievable	Ongoing
		Preventative Action(s): Training is provided to relevant staff as part on the induction Programme. Post-Holder(s) responsible: Unit Managers Discipline Leads Line Manager	Regular feedback to Policy, Procedure, Protocol and Guideline Committee (PPPG) and responsible leads (Unit Managers, Discipline Leads)	Achievable	Ongoing

10. The seclusion rooms were designed with furniture and fittings which posed a potential risk to resident safety. There was no soft padding in the seclusion room, and the observation window frame was designed with metal edges in two seclusion rooms inspected	*New*	Corrective Action(s): Maintenance Department to complete remedial works on metal frame of seclusion room windows. Post-Holder(s) responsible: CNM2 / Maintenance Dept. All unit managers to conduct a risk assessment on the seclusion room on the unit to identify any hazards and risks and address same as per the Risk Management Policy. Post-Holder(s) responsible: Unit Manager Director of Nursing. OMT	Will be reviewed by the Unit Managers, OMT and Maintenance. Maintenance request form sent and inspection on completion of works Any identified risks to be placed on the Risk Register for action and monitoring by OMT.	Achievable Achievable	Jan 19 Regular review of Risk Register
		Preventative Action(s): Consideration will be given to any remedial works that can be approved in view of the building's age and condition. Post-Holder(s) responsible: General Manager			
11. The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist at all in two cases, in a third case it was signed by the consultant psychiatrist but not within the stipulated 24-hour timeframe, 3.5.	*New*	Corrective Action(s): New Seclusion Care Plan – Checklist developed. NCHD to inform Responsible Consultant after initial seclusion. Post-Holder(s) responsible: Treating Consultants Ward Manager	Routine for checking with unit regarding seclusions and forms to be included as part of current review of duties of consultant on call. Checklist will procedurally identify 24hr Consultant review (+all other) and	Achievable	Jan 2019

		NCHD	ensure follow up to mitigate errors.		
		Preventative Action(s): Refresher Training to be provided on the use of seclusion to those responsible for completing the register. Post-Holder(s) responsible: Treating Consultants Ward Manager NCHD		Achievable	Ongoing

Code of Practice: Use of Physical Restraint

Report reference: Page 65

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. 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).	*Reoccurring*	Corrective Action(s): All managers have been tasked with ensuring that all relevant staff have read and understood the TMV policy and signed the appropriate log. A unit based quick reference policy folder and signature log will be held on each unit. Post-Holder(s) responsible: Unit Managers, Discipline Leads Line Manager	Monthly audit of unit policy signature log specific to unit	Achievable	Ongoing
		Preventative Action(s): Training is provided to relevant staff as part on the induction Programme. Post-Holder(s) responsible: Unit Managers Discipline Leads Line Manager	Regular feedback to Policy, Procedure, Protocol and Guideline Committee (PPPG) and responsible leads (Unit Managers, Discipline Leads)	Achievable	Ongoing

Code of Practice; Admission, Transfer and Discharge

Report reference: Pages 66 & 67

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)*
13. Not all relevant staff had signed to indicate that they had read and understood the admission, transfer, and discharge policies, 9.1.	*Reoccurring*	Corrective Action(s): All managers have been tasked with ensuring that all relevant staff have read and understood the Admission, Transfer and Discharge Policies and signed the appropriate log. A unit based quick reference policy folder and signature log will be held on each unit. Post-Holder(s) responsible: Unit Managers, Discipline Leads Line Manager	Monthly audit of unit policy signature log specific to unit	Achievable Staff on leave such as maternity or extended sick leave may not be available to sign.	Ongoing
		Preventative Action(s): Training is provided to relevant staff as part on the induction Programme. Post-Holder(s) responsible: Unit Managers Discipline Leads Line Manager	Regular feedback to Policy, Procedure, Protocol and Guideline Committee (PPPG) and responsible leads (Unit Managers, Discipline Leads)	Achievable	Ongoing

14. The discharge policy did not include the procedure for discharging homeless people, 4.12.	*New*	Corrective Action(s): A working policy sub-group will be set up to review the discharge policy and will present this to the PPPG Committee. In line with our revised PPPG committee objective user representation will be central to this process. This policy has been prioritised for review at a meeting on 14th Dec 2018 Post-Holder(s) responsible: PPPG		Achievable and Realistic	February 2019
		Preventative Action(s): Review of Policy Post-Holder(s) responsible: PPPG committee		Achievable	February 2019
15. Audits had not been completed on the implementation of and adherence to the admission, transfer, and discharge policies, 4.19.	*Reoccurring*	Corrective Action(s): An audit process/cycle to assess the service's compliance with its Admission, Discharge and Transfer policies will be established Post-Holder(s) responsible: PPPG Committee Operational Management Team	Audit of patient files to be completed in line with the Judgement Support Framework	Achievable and Realistic	End of quarter 1 2019
		Preventative Action(s): Audit completion will be tracked/monitored through the service's monthly PPPG committee meeting Post-Holder(s) responsible: PPPG Committee Operational Management Team	Review of audit completed in line with the Judgement Support Framework	Achievable and Realistic	End of quarter 1 2019