Department of Psychiatry, Connolly Hospital

ID Number: AC0020

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, Connolly Hospital
Blanchardstown
Dublin 15

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
7 December 2015

Conditions Attached:
None

Registered Proprietor:
HSE

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

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Martin McMenamin
Elaine Healy
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Inspection Date:
7 – 10 August 2018

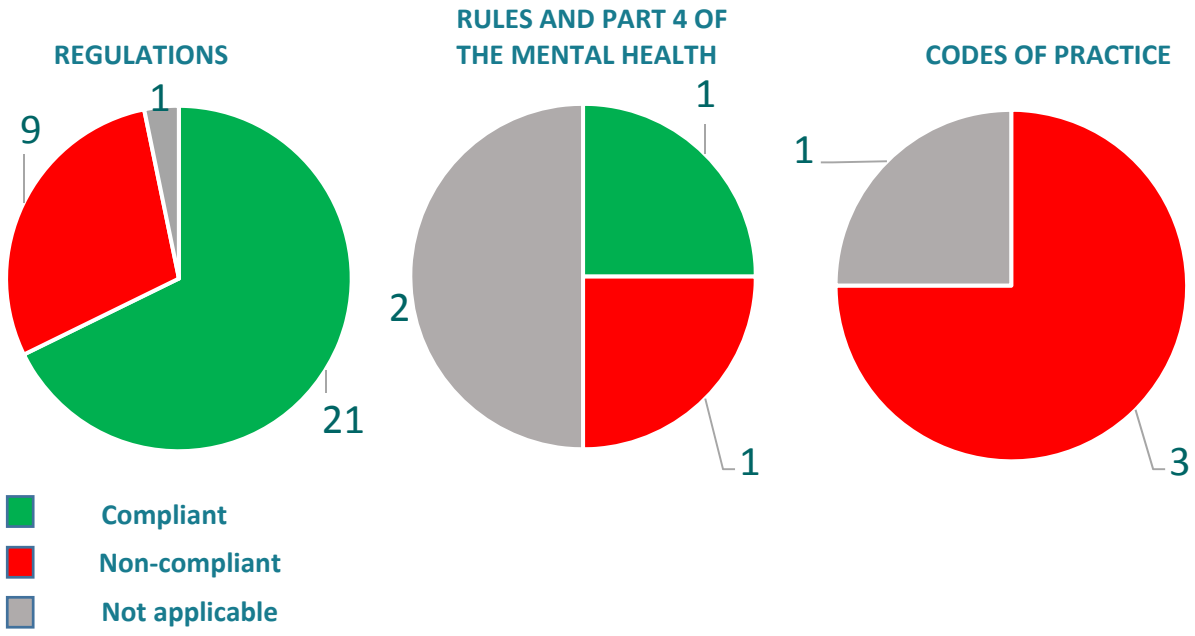
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
26 – 29 September 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
7 February 2019

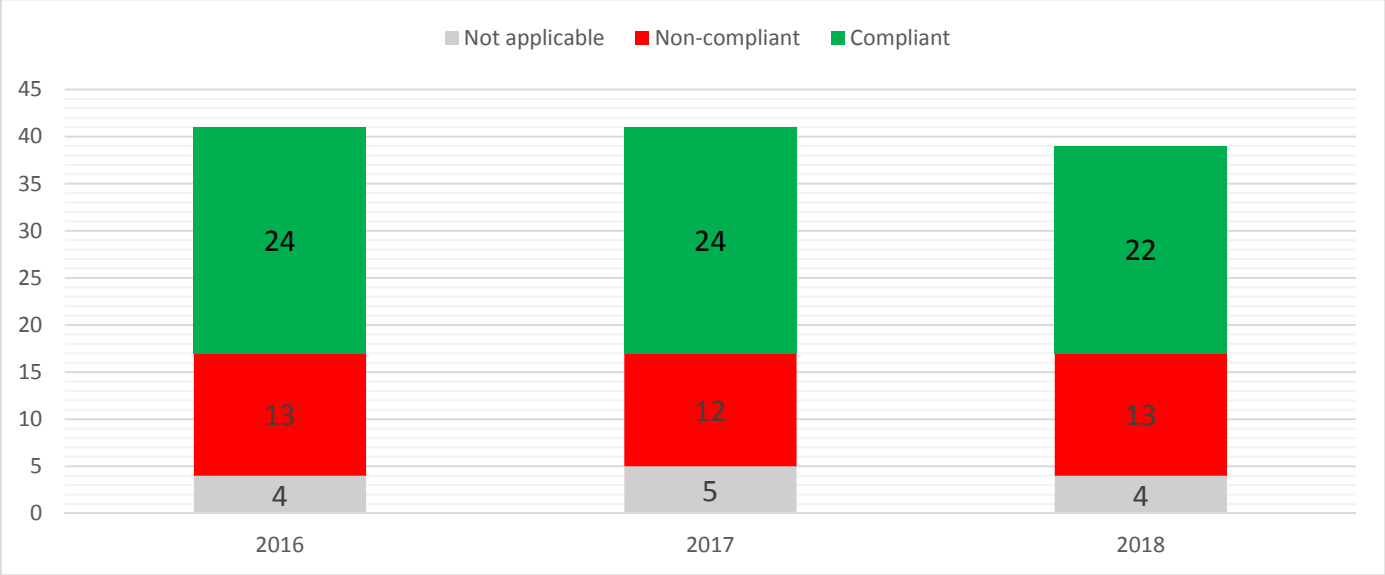
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

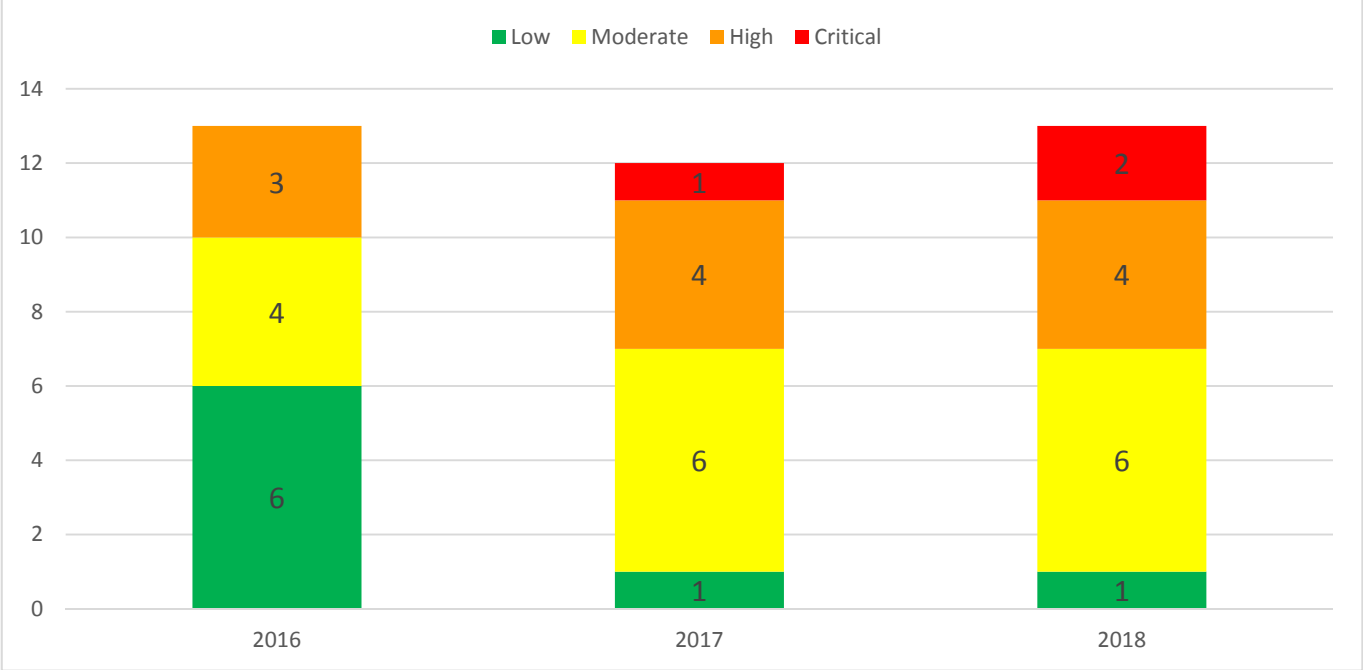
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Introduction to the Inspection Process

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

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

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

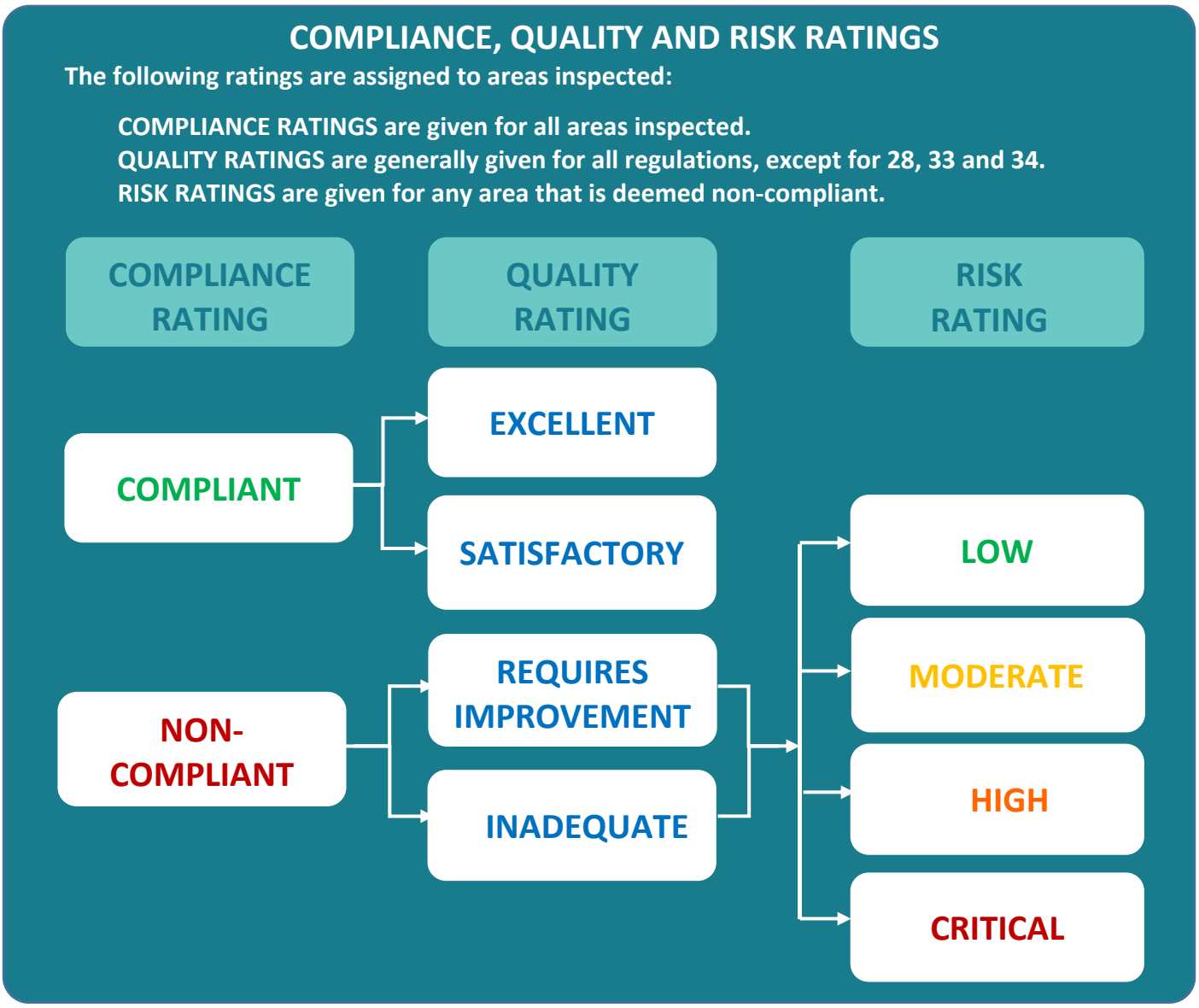
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, 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 Department of Psychiatry was located on lower ground floor of Connolly Hospital in Blanchardstown. It provided acute in-patient care for Dublin North City, which was part of the Community Healthcare Organisation Area (CHO) 9. The Department of Psychiatry provided services to east and west Blanchardstown, Cabra, and Finglas and consisted of two wards Ash and Pine (21 beds each), and a High Dependency Unit (5 beds). Seven consultant-led teams admitted to the approved centre. Two rehabilitation teams and a homeless team also admitted residents to the approved centre.

The approved centre struggled to improve compliance levels. In 2017 it was compliant with 75% of rules, regulations and codes of practice, whereas in 2018 it was compliant with only 63% of requirements. However, there was a quality rating of excellent on four regulations in 2018.

Safety in the approved centre

All residents had at least two personal identifiers. Food safety was audited regularly. The approved centre had introduced a Safe Wards Model, which is an evidence-based approach to reducing conflict and containment in mental health hospitals. Not all health care staff were trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001 and Children First. Medication was ordered, stored and administered safely. Discontinuation dates of medications were not always recorded on prescriptions.

Ligature point risks were not minimised in the approved centre and a serious ligature risk was identified and communicated by the inspectors to staff. When asked by inspectors, residents said they generally felt safe in both wards, however not all residents felt safe in the High Dependency Unit. 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 requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented.

Appropriate care and treatment of residents

The development of individual care plans (ICPs) was unsatisfactory. In three out of 10 ICPs inspected, there was no evidence that the ICPs were developed within seven days of admission. Five of the ICPs inspected did not contain specific, accurate, and appropriately defined goals for the residents; two did not identify the interventions required to meet the goals identified, eight did not include a preliminary discharge plan, one had not been reviewed within the specified time frame and there was no evidence of resident involvement in three ICPs. When asked by inspectors, not all residents felt they had access or were involved in their individual care plans. This is the fourth year in succession that the approved centre has been non-compliant with Regulation 15 on individual care plans for residents, which is unacceptable.

Therapeutic services and programmes were wide-ranging and evidence based. There was an occupational therapy department with two occupational therapists and an occupational therapy assistant in the approved centre. While there was access to medical treatments, six-monthly general health assessments and associated tests were not fully complete. Clinical files inspected were not in good order. Resident records were not developed and maintained in a logical sequence, and ICPs were amalgamated with progress sheets. There was non-compliance with the Rule Governing the Use of Seclusion and the non-compliance with Code of Practice on Physical Restraint. Both of these non-compliances were rated as critical risks. The approved centre was compliant with Part 4 of the Mental Health Act 2001 Consent to Treatment.

Nine children had been admitted to the approved centre since the previous inspection in 2017. The approved centre was non-compliant with the code of practice relating to the admission of children as staff had not received training in relation to the care of children; the nine clinical files inspected did not record each child's understanding of the explanation given to them on their rights. A programme of activities appropriate to the young person's age and ability was available in the approved centre.

Respect for residents' privacy, dignity and autonomy

The doors to Ash and Pine wards and the High Dependency Unit were secured with access via swipe card. The rationale for this restrictive practice was to ensure the safety and welfare of the residents. There were no other restrictive practices identified during the inspection process. Residents wore their own clothes and only wore night clothes during the day if this was indicated in their care plan. Residents had access to their own property while in the approved centre and there was safe storage of valuables.

The clinical file of a resident who was searched showed that, while consent was sought, there was no second member of staff present during the search and the staff member carrying out the search was not of the same gender as the resident. Documentation of searches was also insufficient.

Residents could meet visitors in private and there was access for residents to external communication. Privacy was respected throughout the approved centre, apart from noticeboards, which displayed identifiable resident information on Pine and Ash Wards, which were visible from public areas of the ward. CCTV was used in a manner that respected residents' privacy.

Responsiveness to residents' needs

There was a choice of menu at mealtimes and the food presented was nutritious and wholesome. Residents were complimentary of the food and food choices. There was a wide range of recreational activities during the week and at weekends. Written information about the approved centre, medications and diagnoses was available for all residents. The complaints procedure was satisfactory.

Generally, the approved centre was kept in a good state of repair but it was not clean, hygienic, and free from offensive odours. The approved centre was adequately lit and ventilated with the exception of the seclusion room. The seclusion room ceiling was found to be dirty and the room was gloomy.

There was an inadequate number of toilets, including assisted bathroom facilities, for the residents in the High Dependency Unit. There was also limited access to personal space in the approved centre.

Governance of the approved centre

The approved centre was part of the Health Services Executive (HSE) Community Health Care Organisation (CHO) 9. There was an organisational chart and clear governance structures and processes in place. The mental health management team met on a monthly basis. Heads of disciplines identified strategic goals for their staff and discussed potential operational risks with their departments. Clear lines of responsibility were evident in all departments. Operating policies and procedures were communicated to all relevant staff and most staff had read and understood the policies.

The approved centre had a series of written policies in relation to risk management and incident management procedures. Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register, however, the risk register was not reviewed and audited at least quarterly to determine compliance with the approved centre's risk management policy. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Ash and Pine wards had been painted and new lighting installed to brighten the ward areas. Bathroom in both wards and in the occupational therapy department had been fully renovated since the last inspection.

2. Policies had been updated in line with *the Judgement Support Framework* version 5, and the approved centre had commenced developing quality audits.

3. Introduction of a new individual care plan template and standardised printing of documentation.

4. Commencement of education sessions on medical emergency and use of emergency equipment/crash trolley, and electrocardiogram training for nursing staff.

5. Introduction to coaching and staff development for clinical nurse manager grades 1 and 2.

6. Introduction of an Advanced Nurse Practitioner in Emotional Dysregulation for the Blanchardstown Connolly Mental Health Team.

7. The introduction of a Safe Wards Model, which is an evidence-based approach to reducing conflict and containment in mental health hospitals.

8. The introduction of activity packs for residents in Ash Ward and for minors should they be admitted to the approved centre in future.

9. Residents had access to an exercise group one day a week, which was facilitated by a trained fitness instructor.

10. Introduction of a Health and Wellbeing programme for staff whereby staff had access to a dietitian if required.

11. The Psychology Department had introduced a Living Well Group, which provided psycho-education to enhance emotional coping for residents.

12. Social work information posters for service users and their families had been developed by the social work department. The posters highlighted and promoted the availability of social work services in Connolly Hospital. There was a new poster highlighting the availability of group work as an intervention.

13. A steering group to address hospital delayed discharges was set up in 2018. This was chaired by the Principal Social Worker, with representation from all disciplines and administration.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Department of Psychiatry (DOP) was located on Level one (lower ground floor) of Connolly Hospital in Blanchardstown. The reception area and corridor were spacious and bright with colourful seating areas along the corridor. The approved centre provided acute in-patient care for Dublin North City, which was part of the Community Healthcare Organisation Area 9. The DOP provided services to east and west Blanchardstown, Cabra, and Finglas and consisted of two secure wards Ash, Pine, and a High Dependency Unit (HDU).

Pine and Ash wards each had 21 beds. The bedrooms on both wards comprised of two single rooms, three double rooms, two four bedrooms, and one five bedded room. All bedrooms had en suites, which were bright and had been newly renovated. Ash and Pine wards had been repainted since the last inspection and new lighting had been installed to brighten the ward areas. Both Pine and Ash wards had shared access to a large outdoor space, which was very bland and lacked greenery. The communal sitting areas in Ash and Pine wards were very small and could accommodate eight chairs comfortably.

There were five single bedrooms in the HDU and residents shared toilet and shower facilities. There was very limited access to personal space both internally and externally and the seclusion room was in a poor state of repair and in need of a full refurbishment. The approved centre had plans to renovate the HDU and the seclusion room; work was to commence in mid-September 2018.

Seven consultant-led teams admitted to the approved centre. Three of these community mental health teams were double-sector teams and there was one single-sector team. Two rehabilitation teams and a homeless team also admitted residents to the approved centre.

There were no children in the approved centre on the first day of inspection; however, children had been admitted to the approved centre since the last inspection.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**46**
Number of detained patients	13
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was part of the Health Services Executive (HSE) Community Health Care Organisation (CHO) 9. There was an organisational chart and clear governance structures and processes in place. The mental health management team met on a monthly basis. The minutes of the Mental Health Management team meetings were provided to the inspection team and included finance, HR and staff training, service updates, service user representative, and quality and safety. The minutes of the monthly Quality and Safety Committee meetings were also available. Agendas were robust with evidence of ongoing quality improvement.

Heads of disciplines identified strategic goals for their staff and discussed potential operational risks with their departments, including difficulties in recruiting and retaining staff and accessing training. Clear lines of responsibility were evident in all departments, with heads of discipline attending regular meetings with staff and departments providing supervision to their staff.

The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders. Operating policies and procedures were communicated to all relevant staff. All operating policies and procedures required by the regulations were reviewed within three years.

4.5 Use of restrictive practices

The doors to Ash and Pine wards and the HDU was secured with access via swipe card. The rationale for this restrictive practice was to ensure the safety and welfare of the residents. There were no other restrictive practices identified during the inspection process.

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	
Regulation13: Searches	✓		✓		✗	Moderate
Regulation 15: Individual Care Plan	✗	High	✗	High	✗	High
Regulation 19: General Health	✓		✓		✗	High
Regulation 21: Privacy	✓		✓		✗	Moderate
Regulation 22: Premises	✗	Moderate	✗	Moderate	✗	High
Regulation 23: Ordering, Prescribing, Storing & Administration of Medicines	✗	High	✗	High	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 27: Maintenance of Records	✗	Low	✗	High	✗	High
Regulation 28: Register of Residents	✓		✓		✗	Low
Rules Governing the Use of Seclusion	✗	Low	✗	Moderate	✗	Critical
Code of Practice on the use of Physical Restraint in Approved Centres	✗	Moderate	✓		✗	Critical
Code of Practice Relating to the Admission of Children	✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 7: Clothing
Regulation 10: Religion
Regulation 11: Visits

5.3 Areas that were not applicable on this inspection

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

6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Area Lead from the HSE Mental Health Engagement Office was contacted.

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

Fifteen residents met with the assistant inspectors and provided insights into their experience in the approved centre. Thirteen service user experience questionnaires were returned during the inspection process. Most respondents were complimentary of the care and treatment and found the nursing staff to be helpful. Not all residents felt they had access or were involved in their individual care plans. Residents mentioned they would like a more home-like environment and larger sitting room areas. Feedback suggested that the bedrooms were comfortable and the ward areas were clean.

Residents generally felt safe in both wards, however not all residents felt safe in the High Dependency Unit. Feedback suggested that some residents felt there was not enough activities on the wards, especially on the weekends. Other residents stated that they enjoyed the activities provided by the occupational therapy department. Residents were complimentary of the food and food choices.

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:

- Acting Clinical Director
- Registered Proprietor
- Business Manager
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Staff Nurse
- Occupational Therapy Manager
- Principal Psychologist
- Acting Principal Social Worker

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Discussion was generated with regard to menus and ordering food choices, noticeboards in the nurse's offices, the low incidence of medication errors and improving the appearance of the outdoor space.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: A minimum of two person-specific resident identifiers appropriate to the resident group profile and individual residents' needs were used. The approved centre used name, medical record number, and date of birth of each resident as identifiers. The identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate alerts were used to alert staff of the presence of residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents 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: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Menus were on a three-week rotation. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Food was presented attractively. Residents had two choices for meals, which they pre-ordered from the set menu the day before. There were menu options of halal meat and vegetarian food. Hot and cold drinks were offered to residents regularly. Residents were provided with a source of safe, fresh drinking water at all times through water dispensers, which were located on each ward.

For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The St. Andrew's Nutrition Screening Instrument (SANSI), which was an evidence-based nutrition assessment tool, was used. Their special dietary needs were regularly reviewed by a dietitian. Residents, their representatives, family, and next of kin were not educated about residents' diets.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene commensurate with their role. This training was documented and evidence of certification was available, where appropriate.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety audits.

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. The approved centre provided suitable and sufficient catering equipment. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Clothes were laundered by an outsourced laundry service once a week. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, religious, and cultural practices.

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

Regulation 8: Residents' Personal Property and Possessions

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 residents' personal property and possessions, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safekeeping of residents' monies, valuables, personal property, and possessions. There were two safes in the nurses' area, for monies and valuables. Each unit had a property room where other property was securely stored. However, access to and use of resident monies was overseen by only one staff member, rather than two.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan (ICP). On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident's ICP. The checklist was updated on an ongoing basis, in accordance with the approved centre's 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 evidence of implementation pillar.

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 May 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 resident attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to a range of recreational activities appropriate to the resident group on weekdays and during the weekend. These activities were staff dependent. Recreational activities took place in the occupational therapy area during the week and on the ward at the weekend. Information was provided to residents in an accessible user-friendly format, including the type and frequency of recreational activities. A weekly timetable of activities was available on each ward.

The recreational activities were appropriately resourced. There was one senior occupational therapist, one staff grade occupational therapist, and one occupational therapy assistant. Residents had opportunities to share their opinions in relation to the development of recreational activities at monthly resident meetings.

The activities available in the approved centre included television viewing, computers, books, a newspaper group, cooking and baking, board games, arts and crafts, knitting, gardening including planting, walking outdoors, music, visits to the coffee shop. A pool table, occupational therapy kitchen, and musical instruments were also available in the occupational therapy suite. The internal courtyard was bare.

The communal areas provided were suitable for recreational activities, in small sitting rooms. Attendance at recreational activities was documented in an activities log in each resident's clinical file.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable, and Mass was offered in an on-site prayer room. A prayer mat and a copy of the Quran was available for residents of Muslim denomination. Residents had access to multi-faith chaplains, if required. Chaplains visited the approved centre frequently or as requested. Communion was provided on a daily basis.

Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes. A private area was provided in the approved centre if required by a resident, e.g. for early morning prayers.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Restriction on residents' rights to receive visitors was monitored and reviewed on an ongoing basis. Analysis was completed to identify opportunities to improve visiting processes. This was documented.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed outside the unit doors and within the resident information booklet. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

Clinical files documented the names of visitors residents did not wish to see and those who posed a risk to residents. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. It was possible for visits to take place in separate visiting rooms, which were in use outside of all of the units specifically for visits involving children. The room was safe with a selection of toys.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **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 and procedures in relation to resident communication, which was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents had access to mail, fax, email, internet, and telephone. All residents in Ash and Pine wards had access to their personal mobile phones, and for safety reasons their chargers were left in a separate room. In the High Dependency Unit residents requested to make phone calls when desired. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. A senior staff member only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

Regulation 13: Searches

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 and procedures in relation to the implementation of resident searches, which was last reviewed in June 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: A log of searches was maintained in the High Dependency Unit with all relevant information. An incomplete search log was maintained on the Pine and Ash Wards, which did not detail resident names. Each search record was not systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had not been completed to identify opportunities for improvement of search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was not sought for routine environmental searches.

The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had not been adequately assessed prior to the search of the resident.

The resident was informed by the person implementing the search of what was happening during a search and why. There was not a minimum of two clinical staff in attendance at all times when the search was being conducted; instead, one nurse was present during the search.

The search was implemented with due regard to the resident's dignity and privacy. However, a staff member who conducted one of the searches was not of the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search. An incomplete search log was maintained on the Pine and Ash Wards, which did not detail the resident names, making it difficult to know which search was conducted on which resident. Not all environmental searches were documented.

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

a) **The registered proprietor did not ensure that there was a minimum of two appropriately qualified staff in attendance at all times when searches were being conducted, in one search only one member of staff was present, 13 (6).**
b) **Searches were not undertaken with due regard to the resident's gender, 13 (7).**
c) **There was inadequate written records of environmental searches and written records of searches of residents did not detail the name of the residents being searched, 13 (9).**

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 two written operational policies and protocols in relation to care of the dying. The care of the dying policy was last reviewed in May 2018. The sudden/unexplained death policy was last reviewed in March 2018. The policies combined included the requirements of the *Judgement Support Framework* with the exception of the process for ensuring that the approved centre was informed in the event of the death of a resident who has been transferred elsewhere.

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 for end of life care, as set out in the policies.

As there had been no deaths in the approved centre since the last inspection, the approved centre was only assessed under the two pillars of processes and training and education for this regulation.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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 June 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The ICPs of ten residents were inspected. Each ICP was a composite set of documents stored in the clinical file. However, a number of ICPs were not identifiable and were interrupted. All ICPs inspected were amalgamated with progress notes. Each resident was assessed at admission and an initial care plan was completed by the admitting clinician to address the immediate needs of the resident. In three ICPs inspected, there was no evidence that the ICPs were developed within seven days of admission. A key worker was identified in all 10 ICPs inspected to ensure continuity in the implementation of residents' ICPs.

Five of the ICPs inspected did not contain specific, accurate, and appropriately defined goals for the residents. Two ICPs did not identify the interventions required to meet the goals identified. Eight ICPs did not include a preliminary discharge plan. One ICP had not been reviewed within the specified time frame. There was no evidence of resident involvement in three ICPs. Five ICPs were not drawn up with the family's involvement.

The ten ICPs inspected included an individual risk management plan. ICPS were reviewed by the MDT in consultation with the resident. Residents had access to their ICPs and were kept informed of any changes. Ten residents were not given a copy of their ICP, and in six ICPs, there was no reason documented as to why a copy was not given to the resident. Where a resident declined or refused a copy of their ICP, this was not documented.

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

a) **Three ICPs inspected were not developed by the MDT within seven days of admission.**
b) **ICPs were not recorded in the one composite set of documents.**

c) **Five ICPs inspected did not contain specific and appropriate goals for the residents.**
d) **One ICP had not been reviewed within the specified timeframe.**
e) **Ten residents were not given a copy of their ICP, and in six ICPs, there was no reason documented as to why a copy was not given to the resident.**

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 May 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: All therapeutic services and programmes provided by the approved centre were extensive, evidence-based, and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents. All therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of all therapeutic services and programmes provided in the approved centre was available to residents, through timetables which were displayed on the wards. The occupational therapy department individually distributed the timetables to residents.

Adequate resources and facilities were available including a therapy kitchen, arts and craft room, garden, and workshop room-with computer access was available. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Therapeutic services and programmes were provided in separate dedicated room containing facilities and space for individual and group therapies. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents' clinical files on a weekly basis by the occupational therapy department.

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 residents, which was last reviewed in August 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 the transfer of residents, 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: The clinical file of one resident who had been transferred from the approved centre was examined. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This communication included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and the resident's accompaniment requirements on transfer.

The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident's needs. Relevant documentation was issued as part of the transfer, with copies retained, including a letter of referral with a list of current medications and a resident transfer form. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident's clinical file.

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

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two separate written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which were last reviewed in May 2018. The policies combined included the requirements of the *Judgement Support Framework* with the following exceptions:

- The resource requirements for general health services, including equipment 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: Residents' take-up of national screening programmes was not recorded or monitored. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: Staff in the approved centre had an emergency resuscitation trolley, which was checked daily. They had access at all times to an Automated External Defibrillator.

The five clinical files inspected showed that residents received appropriate general health care interventions in accordance with their documented identified needs in their ICPs. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs.

Resident's general health needs were monitored and assessed at least every six months. While the five residents had received a six-monthly general health assessment including a physical examination, the assessments had not been adequately completed. Residents Body Mass Index was not checked and recorded in three cases. None of the five residents received an assessment of their waist circumference. Smoking status was not documented in any of the five cases. Dental health assessments were not documented.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Residents on antipsychotic medication received an annual assessment of their heart health through an electro-cardiogram assessment. However, five residents on antipsychotic

medication had not yet received an assessment of their glucose regulation, blood lipids, and prolactin levels. Out of these five residents, one resident was admitted to the approved centre more than one year before the inspection time and the four remaining residents had been admitted less than one year since the inspection time.

Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing.

The approved centre was non-compliant with this regulation because the six-monthly general health assessment records and associated tests were not fully complete, 19 (1) (b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents, which was last reviewed in June 2017. The policy included all of 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 residents, as set out in the policy.

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

Evidence of Implementation: Residents were provided with a booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident's diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

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 MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in March 2018. The policy addressed all of 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 could articulate the processes for ensuring resident 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 resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity. This resulted in the identification of suitable screening of external windows and internal courtyard windows.

Evidence of Implementation: Residents were facilitated to make and receive private phone calls. The general demeanour of staff and the way in which staff addressed and interacted with residents was respectful. Residents wore clothes which respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. All of these locks had an override function.

Where a resident shared a room the bed screening was adequate to ensure that their privacy was not compromised. Noticeboards displayed identifiable resident information on Pine and Ash Wards, which were visible from public areas of the ward. This meant residents' privacy and dignity in the approved centre was not appropriately respected and maintained at all times.

The approved centre was non-compliant with this regulation because noticeboards in Ash and Pine Wards displayed identifiable resident information, which meant that resident's privacy and dignity was not appropriately respected and maintained at all times.

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 patients and the safety and well-being of residents, staff and visitors.

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately heated. The seclusion room was poorly ventilated, and all other rooms were adequately ventilated. The lighting in the seclusion room was poor. Lighting in the communal rooms suited the needs of residents and staff for reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs.

Hazards were not minimised. Hard edges were present in the en suite facility of the seclusion room. Ligature point risks were not minimised. At the time of the inspection, the top of the windows in the approved centre were a serious ligature risk. General works were on-going to improve the premises. Bathrooms and toilets in Ash and Pine Wards had been recently refurbished. The High Dependency Unit (HDU) had very limited spaces for residents to move about inside and outside.

There was a cleaning schedule implemented but the approved centre was not clean, hygienic, and free from offensive odours. Two toilets in the HDU were malodourous, with plumbing and sewage issues. The en suite facility in the male multi-occupancy room was also malodourous.

The approved centre was kept in a good state of repair. Ash and Pine wards were repainted recently. There was a programme of general maintenance, decorative maintenance, and repair of assistive equipment. Records were maintained.

Resident bedrooms were appropriately sized to address the resident needs. Suitable furnishings were not provided to support resident independence and comfort. There was an insufficient number of toilets and showers for residents in the approved centre. The HDU had one single toilet for the use of all residents in that unit, and only one assisted bathroom facility.

Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to the implementation for possible impact on current residents and staff. The Mental Health Commission was informed prior to the commencement of works. Remote or isolated areas of the approved centre were monitored. Back-up power was available in the approved centre.

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

a) **The approved centre was not clean, hygienic, and free from offensive odours, 22, 1 (a).**
b) **It was not adequately lit and ventilated throughout, 22, 1 (b).**
c) **Hazards were present, and ligatures had not been minimised. This signified that the physical structure and overall approved centre environment were not developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, 22(3).**
d) **It did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre. There was an inadequate number of toilets including assisted bathroom facility for the residents in the High Dependency Unit. There was also limited access to personal space, 22 (3).**

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

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(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 Connelly Hospital Medication Management Policy was last reviewed in October 2016. The policies combined included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all pharmacy or medical 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. 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 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 been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident 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. Two MPARs did not record the stop date for each medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's MPAR. The signature of the medical practitioner or nurse prescriber was present on each MPAR entry.

Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the resident's care or condition. This was documented in the 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 resident's pharmacist regarding the appropriate use of the product was adhered to.

The controlled drug balance corresponded with the balance recorded in the controlled drug book. The quantity of 380 millilitres of a controlled drug called methadone was not currently prescribed to any resident in the approved centre. This methadone was held in stock for possible use.

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 locked room. Refrigerators

used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. An inventory of medications was conducted on a weekly basis by the pharmacist, 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 resident 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 non-compliant with this regulation because they did not have suitable practices relating to the prescription and administration of medications:

a) **Two MPARs did not record the stop date for each medication.**
b) **One MPAR did not detail the generic name of the medication and preparation.**

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 residents, staff, and visitors. The health and safety policy was last reviewed in June 2017. The policies combined included the requirements of the *Judgement Support Framework* with the exception of details of the specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the 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 a written policy and protocols in relation to the use of CCTV, which was last reviewed in March 2017. The policy included the requirements of the *Judgement Support Framework* with the exception of the process for the disclosure of the existence and usage of CCTV or other monitoring devices to the Inspector of Mental Health Services and/or Mental Health Commission.

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 the use of CCTV, as set out in the policy.

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 where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident 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 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 two written policies and procedures in relation to its staffing requirements. The staffing policy was last reviewed in April 2018. The policies combined included all the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation and effectiveness of the staff training plan were reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: The organisational chart in place 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, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

The number and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was available within the approved centre. Staff were trained in manual handling, infection control and prevention, resident rights, risk management and treatment, incident reporting, and recovery-centred approaches to mental health care and treatment.

Staff were not trained in end of life care and the protection of children and vulnerable adults. Not all health care staff were trained in the following:

- fire safety
- Basic Life Support
- The Professional Management of Violence and Aggression, (PMAV)
- 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*
Ash Ward	CNM2	1	0
	RPN	4	3
	HCA	1 (Mon-Fri)	0
	Psychologist	0.5	0

Ward or Unit	*Staff Grade*	*Day*	*Night*
Pine Ward	CNM2	1	0
	RPN	4	3
	HCA	1 (Mon-Fri)	0
	Psychologist	Referral	0

Ward or Unit	*Staff Grade*	*Day*	*Night*
High Dependency Unit			
	CNM2	1	0
	RPN	2	2
	Psychologist	Referral	0
Coverage for all units	CNM3	2	1
	ADON	1	0
OccupationalTherapy Department	Occupational Therapists (OT)	2	
	OT Assistant	1	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Whole Time Equivalent (WTE).

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, or PMAV, 26(4).**
b) **Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in June 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Residents' records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use. Five clinical files were inspected. Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided. Clinical files inspected were not in good order; four of the five clinical files inspected contained loose pages. Resident records were not developed and maintained in a logical sequence, and ICPs were amalgamated with progress sheets.

Resident records were physically stored together. Resident records were maintained using an identifier which was unique to the resident. Only authorised staff made entries in residents' records, or specific sections therein. Hand-written records were legible, written in black indelible ink, and were readable when photocopied. Not all residents' records included the date, and time for each entry. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was non-compliant with this regulation because records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, 27(1).

Regulation 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

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

INSPECTION FINDINGS

The approved centre had a documented up-to-date, electronic register of residents admitted. The register contained the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006, with the exception of diagnosis on admission or provisional diagnosis on admission were not documented.

The approved centre was non-compliant with this regulation because diagnosis on admission or provisional diagnosis were not documented.

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 April 2018. It included the requirements of the *Judgement Support Framework* with the exception of the process for disseminating operating policies and procedures, in either electronic or hard copy.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had 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, as appropriate. 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 standardised.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

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

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

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 April 2017. The policy and procedures 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 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. There was a dedicated room and waiting room in which to hold tribunals. 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 training and education pillar.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints, which was last reviewed in June 2017. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, 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 policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had not completed and documented. Complaints data was analysed and considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of complaints. The complaints procedure, including how to contact the nominated person, was publicly displayed through noticeboards, and it was detailed within the service user's information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints were dealt with by the nominated person and recorded in the complaints log.

Minor complaints were documented separately to other complaints. There were no timeframes recorded for dealing with minor 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 resident'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 series of written policies in relation to risk management and incident management procedures. The risk management and incident reporting policies were last reviewed in May 2017. The policies included requirements of the *Judgement Support Framework*, with the following exceptions:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor in relation to risk.
- The process of identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre, including organisational risks, structural risks and ligature points, and capacity risks relating to the number of residents in the approved centre.
- The process for maintaining and reviewing the risk register.
- The process for notifying the Mental Health Commission about incidents involving residents of the approved centre.

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

Monitoring: The risk register was not reviewed and audited at least quarterly to determine compliance with the approved centre's risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The three people with responsibility for risk, the mental health manager, risk advisor, and assistant director of nursing, were identified and known by all staff. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Neither residents nor their representatives were involved in individual risk management processes.

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

While the new bathrooms in Pine and Ash wards were ligature free, ligature points were not minimised throughout the entire approved centre. The risk management procedure did not actively reduce identified risks to the lowest practicable level of risk. Ligature points were present at the top of the windows in the approved centre, which were considered a serious risk.

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

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

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 **CRITICAL**

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The policy was last reviewed in April 2018. The policy included all of the guidance criteria of this code pursuant to Section 69 of the Mental Health Act 2001, including who may implement seclusion, the provision of information about seclusion to the resident, and the ways of reducing rates of seclusion use.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings, which posed a risk to resident safety. The en suite facility of the seclusion room had numerous ligatures, including a sharp edge in the wash basin. The seclusion room ceiling was dirty, and the overall environment of the seclusion room was gloomy. This meant the seclusion facilities were not furnished, maintained, and cleaned to ensure respect for residents' dignity and privacy. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified verbally on the use of seclusion within the appropriate time frame.

The clinical files of three residents who had been in seclusion on one occasion each were inspected. In all episodes, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. Cultural awareness and gender sensitivity were demonstrated. Residents were informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. Each resident was informed of the ending of seclusion on every occasion. The reason for ending seclusion was recorded on the clinical file in each case.

In one seclusion episode, the seclusion order was not recorded in the clinical file or seclusion register by the registered medical practitioner. In one seclusion episode, there was no evidence that the seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24

hours. There was no date on the seclusion record. In one seclusion episode, the registered medical practitioner did not complete and detail the duration of the seclusion order.

Each episode of seclusion was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode of seclusion.

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

a) **The seclusion room en suite had ligatures, which endangered patient safety, 8.3.**
b) **The seclusion room ceiling was dirty and gloomy, which indicated that the seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, 8.2.**
c) **In one seclusion episode, the seclusion order was not recorded in the clinical file and seclusion register by the registered medical practitioner, 3.4 (b).**
d) **In one seclusion episode, there was no evidence that the seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. There was no date on the seclusion record, 3.5.**
e) **In one seclusion episode the registered medical practitioner did not complete and detail the duration of the seclusion order, 3.4 (c).**

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 patient, means consent obtained freely without threat or inducements, where –

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In both cases, there was documented evidence that the consultant psychiatrist had undertaken a capacity assessment, which measured the patients' ability to consent to receiving treatment. Following the capacity assessment, one patient was deemed unable to consent to receiving treatment and one patient was deemed able to consent to receiving treatment.

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

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

- The effects of the medications(s), including any risks and benefits.

In relation to the patient who was unable to consent to treatment, a *Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* had been appropriately completed. The form evidenced the following:

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

All forms were completed within the appropriate timeframe.

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 **CRITICAL**

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in April 2018. The policy addressed all of the policy-related relevant items of this code of practice, including the provision of information to the resident, those who can initiate and who may implement physical restraint, and child protection process were a child is physically restrained.

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

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: The files of three residents who had been physically restrained since the last inspection were reviewed. In two of the three episodes, physical restraint was used in rare and exceptional circumstances only.

However, in one episode there was no documented evidence to indicate the following:

- That physical restraint was used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others.
- That the use of physical restraint was based on a risk assessment of this resident.
- That staff had first considered all other interventions to manage the resident's unsafe behaviour.

In one of the three physical restraint episodes inspected, cultural awareness and gender sensitivity were not demonstrated when considering the use of and when using physical restraint. Two male nurses subjected one female resident to physical restraint, meaning that a same sex staff member was not present at all times during the physical restraint episode. In addition, there was no record to indicate that this resident had received a medical exam, by a registered medical practitioner within three hours after the start of the physical restraint episode.

In one episode of physical restraint, the clinical practice form was not signed by the consultant psychiatrist within 24 hours. In two episodes of physical restraint, residents were not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was not documented in either case.

In three episodes of physical restraint, the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in two cases. In all three physical restraint episodes, there was no documented record to indicate that each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode.

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

a) **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).**
b) **In one of three physical restraint episodes reviewed there was no documented evidence to indicate the following:**
   - **That physical restraint was used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others, 1.1.**
   - **That the use of physical restraint was based on a risk assessment of this resident, 1.7.**
   - **That staff had first considered all other interventions to manage the resident's unsafe behaviour, 1.2.**
   - **Cultural awareness and gender sensitivity were not demonstrated when considering the use of and when using physical restraint, 1.9. Two male nurses subjected one female resident to physical restraint.**
   - **The same sex staff member was not present at all times during physical restraint episode, 6.3.**
   - **There was no record to indicate that this resident had received a medical exam at all, by a registered medical practitioner within three hours after the start of the physical restraint episodes, 5.4.**
c) **In one episode of physical restraint, the clinical practice form was not signed by the consultant psychiatrist within 24 hours, 5.7 (c).**
d) **In two physical restraint episodes, residents were not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was not documented in either case, 5.8.**
e) **In three episodes of physical restraint the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in two cases, 5.9 (a).**
f) **In all three physical restraint episodes, there was no documented record to indicate that each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode, 9.3.**

Admission of Children

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of children, which was last reviewed in May 2018. It addressed the requirement for each child to be individually risk-assessed and the procedures for identifying the person responsible for notifying the Mental Health Commission (MHC) of the child admission. The policy also detailed procedures in relation to family liaison, parental consent, and confidentiality.

Training and Education: Staff had not received training in relation to the care of children.

Evidence of Implementation: There had been nine child admissions since the last inspection. The clinical files inspected indicated that provisions were in place to ensure the safety of the children, to ensure their rights to have their views heard, and to respond to the child's particular needs as a young person in an adult setting. Staff having contact with children had undergone Garda vetting, and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was available for children in the approved centre, including age and gender segregated sleeping and bathroom areas. Gender sensitivity was demonstrated in each case. The children had their rights explained and were provided with information about the available facilities in a form and language that they could understand. The clinical files did not record each child's understanding of the explanation given to them on their rights.

Advice from the Child and Adolescent Mental Health Service was available when necessary. Consent for treatment was obtained from one or both parents. Educational requirements did not apply because the admission periods were short in duration, ranging from two to ten days. The MHC was notified of the child admissions to an approved centre for adults within the required 72-hour time frame.

A programme of activities appropriate to the young person's age and ability was available in the approved centre.

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

a) **Staff had not received training in relation to the care of children, 2.5 (e).**
b) **The nine clinical files inspected did not record each child's understanding of the explanation given to them on their rights, 2.5 (h).**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in June 2017, the transfer policy was last reviewed in April 2017, and the discharge policy was last reviewed in May 2018. The policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident was estranged from his/her family members, so family were not involved in the admission process. The resident 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 resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan did not document the estimated date of discharge, instead the words 'not applicable' were detailed next to the estimated date of discharge. All other aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team (MDT) and the resident's family. A pre-discharge assessment was completed which addressed the resident'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. Family members were involved in the discharge process.

There was appropriate MDT input into discharge planning. A preliminary discharge summary was issued within three days. A comprehensive discharge summary was issued within 14 days to relevant personnel. The discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

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

a) **Audits had not been completed on the implementation of and adherence to the transfer policy, 4.19.**
b) **The estimated date of discharge was not documented in the discharge plan, 34.2.**
c) **Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 13: Searches

Report reference: Page 27 - 28

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. The registered proprietor did not ensure that there was a minimum of two appropriately qualified staff in attendance at all-time where searches were being conducted, in one search only one member of staff was present, 13(6).	*New*	Corrective Action(s): All staff to be reminded of departments Policy on search of a resident and ensure two staff in attendance at all time during Search Post-Holder(s) responsible: Clinical Nurse Manager 2/ Staff Nurse	Auditing documentation surrounding search of resident. Measure resident experience through Metrics.	Achievable	Immediate
		Preventative Action(s): all staff to be reminded of departments Policy on search of a resident and adhere and document same. Post-Holder(s) responsible: CNM2/Staff Nurse	Audit documentation annually.	Achievable	Annual Audit
2. Searches were not undertaken with due regard to the resident's gender, 13(7).	*New*	Corrective Action(s): All staff to be reminded of departments Policy on search of a resident and to facilitate residents regard in relation to gender specific preference when carrying out a search. Post-Holder(s) responsible: CNM2/Staff Nurse	Auditing documentation surrounding Search of a Resident. Patient experience from Metrics Report.	Barriers include short fall of certain gender availability of staff.	Immediate

		Preventative Action(s): To ensure that Residents sensitivity to gender is taken into regard. Post-Holder(s) responsible:CNM2/Staff Nurse	Patient Experience Metrics	Short Fall of certain gender availability.	Monthly Metrics audit
3. There was inadequate written records of environmental searches, 13(9).	*New*	Corrective Action(s): To include section for environmental searches in search log. Post-Holder(s) responsible: CNM2/Staff Nurse	Auditing log of environmental searches.	Achievable	Immediate
		Preventative Action(s): To ensure that all staff are aware and comply with policy in relation to searches. Post-Holder(s) responsible: CNM3/CNM2/Staff Nurse	Auditing documentation relating to environmental searches.	Achievable	Annual audit
4. Written records of searches of residents did not detail the name of the residents being searched, 13(9).	*New*	Corrective Action(s): To Update Record book to Include residents MRN in search Record Post-Holder(s) responsible: Clinical Nurse Manager 2 /Staff Nurse	Auditing of Searches carried out.	Achievable	Immediate
		Preventative Action(s): To ensure that all staff are aware and comply with policy in relation to searches. Post-Holder(s) responsible: CNM3/CNM2/ Staff nurses	Auditing search log in wards.	Achievable	Annual Audit

Regulation 15: Individual Care Plan

Report reference: Page 30 - 31

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
5. Three ICPs inspected were not developed by the MDT within seven days of admission.	*Reoccurring*	Corrective Action(s):To ensure ICP are developed within specified timeframe Post-Holder(s) responsible: Responsible Clinician for resident	Audits of ICP	Achievable	Audited on quarterly basis.
		Preventative Action(s): ICP are to be developed appropriately within specific time frame. Post-Holder(s) responsible: Responsible Clinician for resident	Audit of ICP	Achievable	Audited on quarterly basis.
6. ICPs were not recorded in the one composite set of documents.	*New*	Corrective Action(s): All current ICP to be recorded as the one composite set of documents. Post-Holder(s) responsible: Ward Administration Staff/CNM2	Audit of ICP	Achievable	Audited on quarterly basis.
		Preventative Action(s): Ensure that current ICP is filed in resident current clinical file. Post-Holder(s) responsible: Ward Administration Staff/CNM2	Audit of ICP	Achievable	Audited on quarterly basis.
7. Five ICPs inspected did not contain specific and appropriate goals for the residents.	*Reoccurring*	Corrective Action(s): Memo from CD to MDT to remind team that all residents ICP should include specific and appropriate goals. Post-Holder(s) responsible: CD and Responsible Clinician for resident	Patient Experience in Metrics audit. ICP Audits.	Achievable	Immediately

		Preventative Action(s): To include identified specific goals during weekly review of ICP Post-Holder(s) responsible: Responsible Clinician for resident	Patient Experience in Metrics Audit. ICP Audits	Achievable	Monthly Metrics Audit & ICP quarterly audits
8. One ICP had not been reviewed within the specified timeframe.	*New*	Corrective Action(s): To review ICP in a designated timeframe Post-Holder(s) responsible: Responsible Clinician for resident	ICP Audits	Achievable	Immediate
		Preventative Action(s): Review dates to be set and recorded at weekly MDTs. Post-Holder(s) Responsible Clinician for resident	ICP Audits	Achievable	ICP quarterly audits
9. Ten residents were not given a copy of their ICP, and in six ICPs there was no reason documented as to why a copy was not given to the resident.	*New*	Corrective Action(s): To ensure each resident is offered a copy of their ICP. If not given a copy to document reason for same Post-Holder(s) responsible: Responsible Clinician for resident	ICP Audits	Achievable	Immediate
		Preventative Action(s): To document in residents ICP that they were given a copy and signed for same. If not given rationale must be documented. Post-Holder(s) responsible: MDT	ICP Audits	Achievable	ICP quarterly audits

Regulation 19: General Health

Report reference: Page 34 - 35

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
10. The six-monthly general health assessment records and associated tests were not fully complete, 19(1). Residents Body Mass Index was not checked and recorded in three cases. None of the five residents received an assessment of their waist circumference. Smoking status was not documented in any of the five cases. Dental health assessments were not documented.	*New*	Corrective Action(s): To ensure that all physical assessments are recorded accurately and completed within specific time frame. Post-Holder(s) responsible: Responsible Clinician for resident	Admin Staff to monitor dates of all physicals.	Achievable	Immediate
		Preventative Action(s): New updated 6 Monthly physical Tool which includes waist circumference, smoking status and dental assessment available in shared drive so easily accessible. Post-Holder(s) responsible: Responsible Clinician for resident	Audit documentation of six monthly assessments	Achievable	Bi annually

Regulation 21: Privacy

Report reference: Pages 38

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
11. Noticeboards in Ash and Pine Wards displayed identifiable resident information, which meant that resident's privacy and dignity was not appropriately respected and maintained at all times.	*New*	Corrective Action(s): We will review positioning of the boards. Post-Holder(s) responsible: CNM3/CNM2	When no longer visible from office Window.	Design/Layout of Office.	Jan 2019
		Preventative Action(s): To ensure noticeboards are not visible from corridor. Post-Holder(s) responsible: CNM3/CNM2	When No Longer Visible	Design/Layout of Office.	Jan 2019

Regulation 22: Premises

Report reference: Pages 39 - 40

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
12. The approved centre was not clean, hygienic, and free from offensive odours, 22, 1 (a)	*New*	Corrective Action(s): To ensure approved centre is clean, hygienic and free from offensive odours Post-Holder(s) responsible: Cleaning Staff/CNM2	Daily observation of ward cleanliness Hygiene Audit	Achievable	Immediate
		Preventative Action(s): To provide and ensure daily cleaning routine is adhered to and documented. Address any offensive odours in a timely fashion. To supply Chemical Free Air Fresheners supplied by Hygiene Vision Post-Holder(s) responsible: Cleaning Supervisor /CNM2	Daily observation of ward cleanliness Hygiene Audit	Achievable	Annual Audit
13. It was not adequately lit and ventilated throughout, 22, 1 (b).	*New*	Corrective Action(s): New lighting has been installed. To review ventilation in the approved centre. Post-Holder(s) responsible: ADON/Estates	Audit of Premises	Achievable	Feb 2019
		Preventative Action(s): continual review of lighting/ventilation with estates. Post-Holder(s) responsible: Estates	Audit of Premises	Achievable	Annual audit
14. Hazards were present, and ligatures had not been minimised. 22 (3).	*Reoccurring*	Corrective Action(s): Ligature audit completed and areas identified are under review to reduce known hazards, Post-Holder(s) responsible: Service Manager/ADON	Ligature Audit	Achievable	On-going
		Preventative Action(s): To continual review and identify and minimise hazards.	Ligature Audit. Risk Assessment	Achievable	Annual audit

		Post-Holder(s) responsible ADON/CNM3/2.			
15. There was an inadequate number of toilets including assisted bathroom facility for the residents in the high dependency unit. There was also limited access to personal space, 22(3).	*New*	Corrective Action(s): Renovation works to commence in HDU on Monday 19th November Plan to include more toilets and sitting area. Post-Holder(s) responsible: Service Manager	Review works when completed	Achievable	3 Months approx.
		Preventative Action(s): To review renovations works regularly during renovation process. Post-Holder(s) responsible: Service Manager/ADON		Achievable	3 Months approx.

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

Report reference: Pages 41 - 42

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
16. Two MPARs did not record the stop date for each medication. 17. One MPAR did not detail the generic name of the medication and preparation.	*Reoccurring*	Corrective Action(s): Check all MPARs to ensure stop date is included. Post-Holder(s) responsible: Consultant/NCHD Check all MPARs to ensure the generic name of the medication and preparation is included. Post-Holder(s) responsible: Consultant/NCHD	Metrics auditing tool	Achievable	Nov 28th 2018
		Preventative Action(s): For all perscribers to attend scheduled Lecture on Safe Perscribing by Senior Clinical Pharmacist. Same scheduled for Febuary 2019. Post-Holder(s) Clincial Director & Clinical Tutor	Attendance Register will be completed for Lecture. 6 Monthly Audit completed by NCHD	Achievable	April 2019

Regulation 26: Staffing

Report reference: Pages 45 - 47

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
18. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, or PMAV, 26(4). 19. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26 (5).	*Reoccurring*	Corrective Action(s): On - going training is being facilitated by the service. Difficulties arise with shortages and releasing staff, however there is a schedule of training in place which is being addressed by all HOD A Memo from management team to all staff emphasising the requirements to complete mandatory trainings and MHA 2001. . Post-Holder(s) responsible: Heads of Discipline.	On-going monitoring by the respective Head of Discipline	This action is reliant on the availability of training and staff to either run the training or for the staff to be released.	3 Monthly review.
		Preventative Action(s): Each Head of Discipline will monitor training registers Post-Holder(s) responsible: Head of Discipline	On-going monitoring by the respective Head of Discipline	This action is reliant on the availability of training and staff to either run the training or for the staff to be released	3 Monthly review.

Regulation 27: Maintenance of Records

Report reference: Pages 48

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
20. The records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, 27(1).	*Reoccurring*	Corrective Action(s): We have introduced new dividers into all charts. Higher quality of paper has been sourced and introduced to all charts Post-Holder(s) responsible: Administrative Staff/CNM2	Measurable Audit	Achievable	Immediate
		Preventative Action(s): To ensure that Records are maintained in an accurate and complete fashion with user friendly and tidy layout of chart. Post-Holder(s) responsible: Administrative Staff/CNM2	Weekly Checks Audit	Achievable	Annual Audit

Regulation 28: Register of Residents

Report reference: Page 49

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
21. Diagnosis on admission or provisional diagnosis were not documented.	*New*	Corrective Action(s):To ensure Provisional Diagnosis is documented in Database Post-Holder(s) responsible: Grade V Administrator	Daily audit	Achievable	Immediate
		Preventative Action(s): That all provisional Diagnosis recorded in Database on admission Post-Holder(s) responsible: Grade V Administrator	Audit	Achievable	Annual audit

Rules: Section 69 the Use of Seclusion

Report reference: 67

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
22. The seclusion room had ligatures, which endangered patient safety, 8.3. 23. The seclusion room ceiling was dirty and gloomy, which indicated that the seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, 8.2.	*New*	Corrective Action(s): As part of renovations works HDU to commence 19th November, a new Seclusion room will be constructed. Post-Holder(s) responsible: Registered proprietor.	Upon Completion of Upgrade	Achievable	Approx. 3 months.
		Preventative Action(s): ligature Audit to be conducted upon completion of upgrade of HDU/Seclusion room. Post-Holder(s) responsible: Registered Proprietor	Upon Completion of Upgrade	Achievable	Approx. 3 Months.
24. In one seclusion episode, the seclusion order was not recorded in the clinical file and seclusion register by the registered medical practitioner, 3.4 (b). 25. In one seclusion episode, there was no evidence that the seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. There was no date on the seclusion record, 3.5. 26. In one seclusion episode the registered medical practitioner did not complete and detail the duration of the seclusion order, 3.4 (c).	*Reoccurring*	Corrective Action(s): Responsible Consultant completes appropriate documentation and within the specified time frame as set by the Mental Health Act (2001) Post-Holder(s) responsible: Responsible Clinician	Quarterly Audits	Achievable	Next Audit 22/11
		Preventative Action(s): To communicate via MEMO with consultants their responsibilities in completing relevant documentation in specified time frame. Post-Holder(s) responsible: Clinical director	Quarterly Audits	Achievable	Next Audit 22/11

Codes: The Use of Physical Restraint

Report reference: Pages 65 - 66

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
27. 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).	*New*	Corrective Action(s):To ensure all staff have signed policy log Post-Holder(s) responsible: All Head of Disciplines	Heads of Disciplines to ensure all staff aware.	Achievable	Immediate
		Preventative Action(s): all HOD's to maintain a signature log for policies to indicate that all staff have read and understood the policy Post-Holder(s) responsible: All Heads of Discipline	Heads of Disciplines to ensure all staff aware of same.	Achievable	Immediate
28. In one of three physical restraint episodes reviewed there was no documented evidence to indicate the following: • That physical restraint was used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others, 1.1. • That the use of physical restraint was based on a risk assessment of this resident, 1.7. • That staff had first considered all other interventions to manage the resident's unsafe behaviour, 1.2 • Cultural awareness and gender sensitivity were not demonstrated when considering	*New*	Corrective Action(s): All nursing staff in department were informed of code of practice on physical restraint. As per Report stated and accepted to MHC regulatory compliances board there was 2 Female staff present during physical restraint. Staff to demonstrate cultural awareness and gender sensitivity when carrying out physical restraint.	Inform all staff	Resource dependant. Deficit of gender specific RPN.	Completed October 2018.

the use of and when using physical restraint, 1.9. Two male nurses subjected one female resident to physical restraint. • The same sex staff member was not present at all times during physical restraint episode, 6.3. • There was no record to indicate that this resident had received a medical exam at all, by a registered medical practitioner within three hour after the start of the physical restraint episodes, 5.4.		All Staff to ensure documentation reflects all staffs identity and gender that were present during restraint. Medical Staff to perform a physical examination of the resident within 3 hours following a physical restraint. Post-Holder(s) responsible: ADON/CNM3/ Responsible Clinician			
		Preventative Action(s): To ensure specific documentation reflects all staffs identity and gender that were present during restraint. Post-Holder(s) responsible: All Staff.	Inform All Staff	Resource Dependant. Deficit of Gender Specific RPN	Quarterly audits
29. In one episode of physical restraint, the clinical practice form was not signed by the consultant psychiatrist within 24 hours, 5.7 (c).	*New*	Corrective Action(s): To ensure that Clinical consultant has signed clinical practice form within specified time frame. Post-Holder(s) responsible: Responsible Clinician for resident	Quarterly Audit	Achievable	Quarterly Audits
		Preventative Action(s): That Consultants are made aware through e-mail that it is their responsibility to complete clinical practice forms within specific time frame. Post-Holder(s) responsible: clinical Director	Quarterly Audit	Achievable	Quarterly Audit

30. In two physical restraint episodes, resident were not informed of the reasons for, duration of and circumstances leading to discontinuation of physical restraint. The reasons for not informing them was not documented in either case, 5.8.	*New*	Corrective Action(s): To ensure all staff complies with code of practice and documentation should include if resident was/was not informed of the reason for duration, and circumstances leading to discontinuation of a physical restraint. Post-Holder(s) responsible: All Staff	Quarterly Audit	Achievable	Immediate
		Preventative Action(s): To introduce Physical Restraint Bundles to ensure compliance of all documentation in coherent and inclusive fashion. Post-Holder(s) responsible: ADON/CNM3/CNM2	Quarterly Audit	Achievable	2 Months
31. In three episodes of physical restraint the resident's next of kin was not informed about the physical restrain and the reasons for not informing them was not documented in two cases, 5.9 (A).	*New*	Corrective Action(s): To ensure that staff include documentation of Next of kin and rationale if not informed. Post-Holder(s) responsible: CNM2/Staff Nurse	Quarterly Audit	Achievable	immediate
		Preventative Action(s): introduction of Physical Restraint Bundle to ensure effective documentation and communication with NOK after all incidents of restraints. Post-Holder(s) responsible: ADON/CNM3/CNM2	Quarterly Audit	Achievable	2 Months

32. In all three physical restraint episodes, there was no documented record to indicate that each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode, 9.3.	*New*	Corrective Action(s): To ensure that MDT is completed within specific time frame. Post-Holder(s) responsible: Residents Responsible Clinician	Quarterly Audit	Achievable	Immediate
		Preventative Action(s): To introduce the Physical Restraint bundles to the use and correct recording of physical restraint and MDT review within specific time frame. Post-Holder(s) responsible: CD/ADON/CNM3	Quarterly Audit	Achievable	2 Months

Codes: Admission of Children

Report reference: Page 77

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
33. Staff had not received training in relation to the care of children, 2.5 (e).	*New*	Corrective Action(s): To ensure all staff have completed Mandatory Childrens 1st Training. To comply and update CPD database to monitor all staff that have completed same. Post-Holder(s) responsible: Heads of Disciplines	Audit of Children 1st CPD Training database.	Achievable	Annually
		Preventative Action(s): All Children should be referred to CAMHS Service. All staff participate in mandatory Children 1st training Post-Holder(s) responsible: CD & All Consultants	Audit of Children 1st CPD training Database	Achievable	Annually
34. The nine clinical files inspected did not record each child's understanding of the explanation given to them on their rights, 2.5 (h).	*New*	Corrective Action(s): CD to request Consultants if a Child is admitted under their care to record the child's understanding of the explanation given to them on their rights Post-Holder(s) responsible: CD	Auditing of Chart	Achievable	Annual audit
		Preventative Action(s): To ensure treating team records the child's understanding of their rights and capacity. Post-Holder(s) responsible: Clinical Director	Auditing of Chart Patient Experience in Metrics Audit.	Achievable	Annual audit on Admission of Children
		Preventative Action(s): Programme of age appropriate activities will be provided by OT staff. Activity pack will be available in each ward (Safewards). Posters displayed on each unit hightlight availability of age appropriate activites. Post-Holder(s) responsible: Clinical Director, Occupational Therapist	Audit on Admission of Children	Achievable	April 2019

Code : Admission, Transfer and Discharge

Report reference: Page 68 - 69

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
35. Audits had not been completed on the implementation of and adherence to the transfer policy, 4.19.	*Reoccurring*	Corrective Action(s):To complete Audit of transfer policy Post-Holder(s) responsible: ADON/CNM3	Audit Report	Achievable	2 Months
		Preventative Action(s): To ensure that a yearly Audit is completed on implementation of and adherences to transfer policy. Post-Holder(s) responsible: ADON/CNM3	Audit Report	Achievable	Annually
36. The estimated date of discharge was not documented in the discharge plan, 34.2.	*New*	Corrective Action(s): To include an estimated date of discharge in discharge planning. Post-Holder(s) responsible: Residents responsible Clinician	ICP Care Plan Audits	Achievable	Quarterly
		Preventative Action(s): To advice all members of the MDT to include an estimated discharge date when discharge planning. Post-Holder(s) responsible: Lead Clinician/MDT	ICP Care Plan Audits	Achievable	Quarterly
37. Not all relevant staff had signed the policy log to indicate that they had	*Reoccurring*	Corrective Action(s): To ensure that all staff sign policy log to indicate that they	Communicated by Heads of Discipline	Achievable	Immediately

read and understood admission, transfer and discharge policies, 9.1.		had understood and read admission transfer and discharge policy. Post-Holder(s) responsible: All Heads of Department.			
		Preventative Action(s): To Remind All Head of Disciplines to ensure staff have signed the signature log. Post-Holder(s) responsible: Head of Disciplines	Communicated by Heads of Discipline	Achievable	Immediately.