MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Department of Psychiatry, Letterkenny University Hospital

ID Number: AC0086

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry,
Letterkenny University Hospital
Circular Road
Letterkenny
Co Donegal

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health care/Long Stay
Psychiatry of Later Life
Mental Health Care for People with Intellectual Disability
Child and Adolescent Mental Health Care

Most Recent Registration Date:
14 September 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Teresa Dykes, General Manager, Mental Health, CHO 1

Inspection Team:
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Inspection Date:
22 – 25 May 2018

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
27– 30 June 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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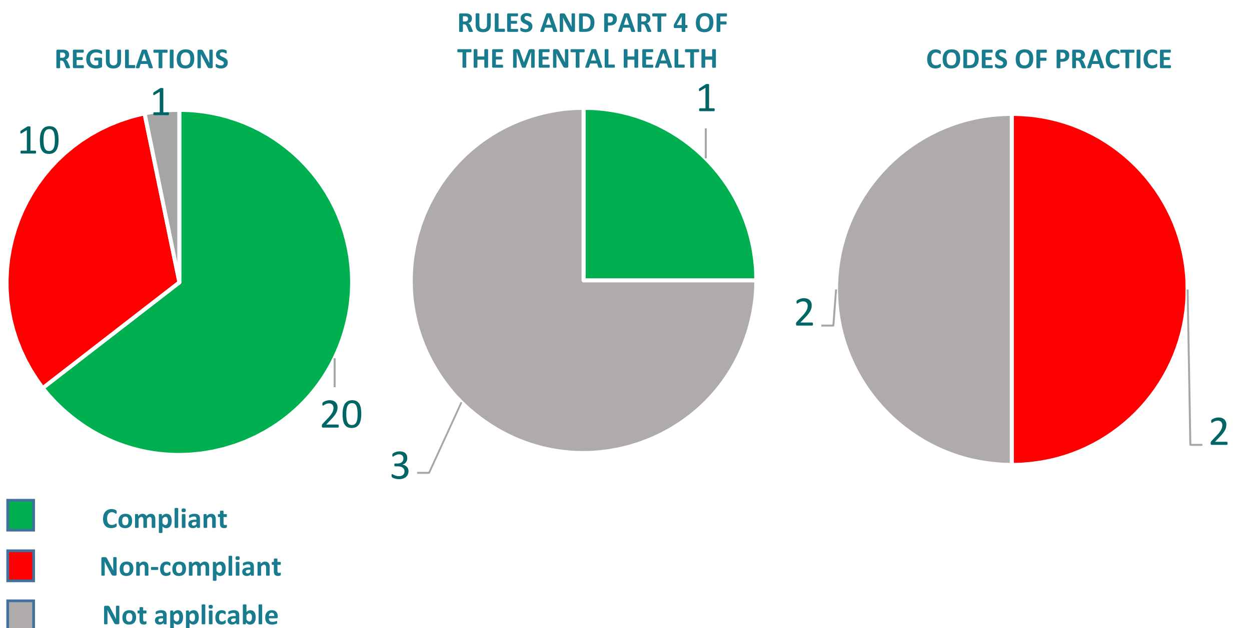
17 January 2019

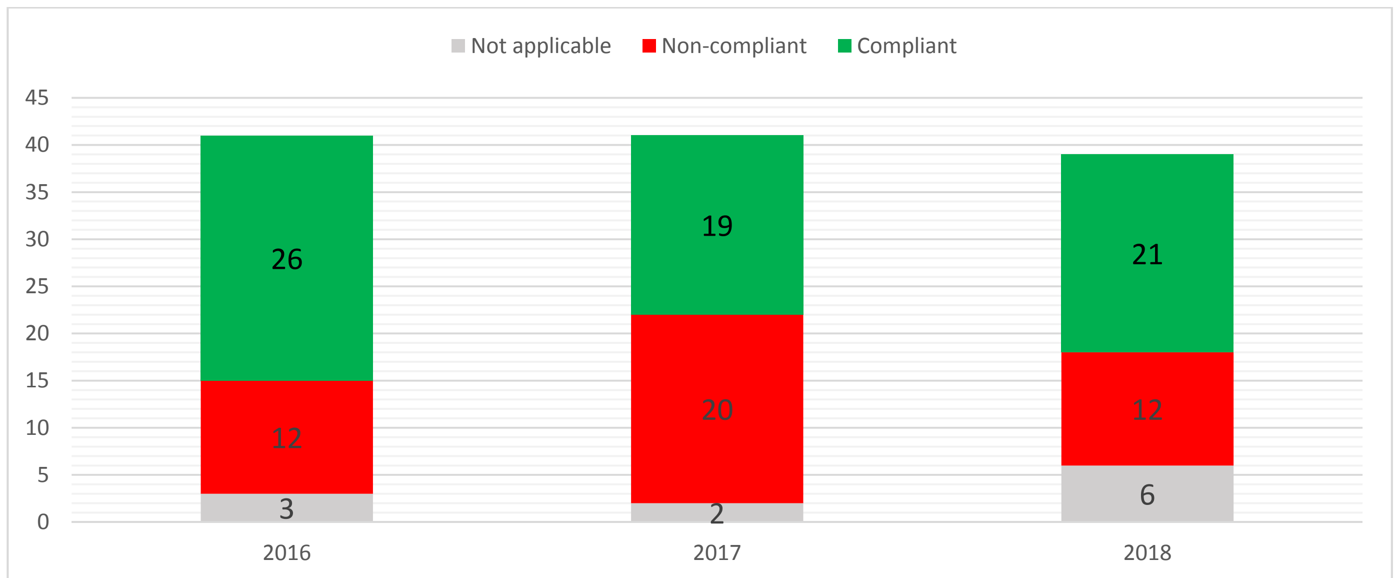
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

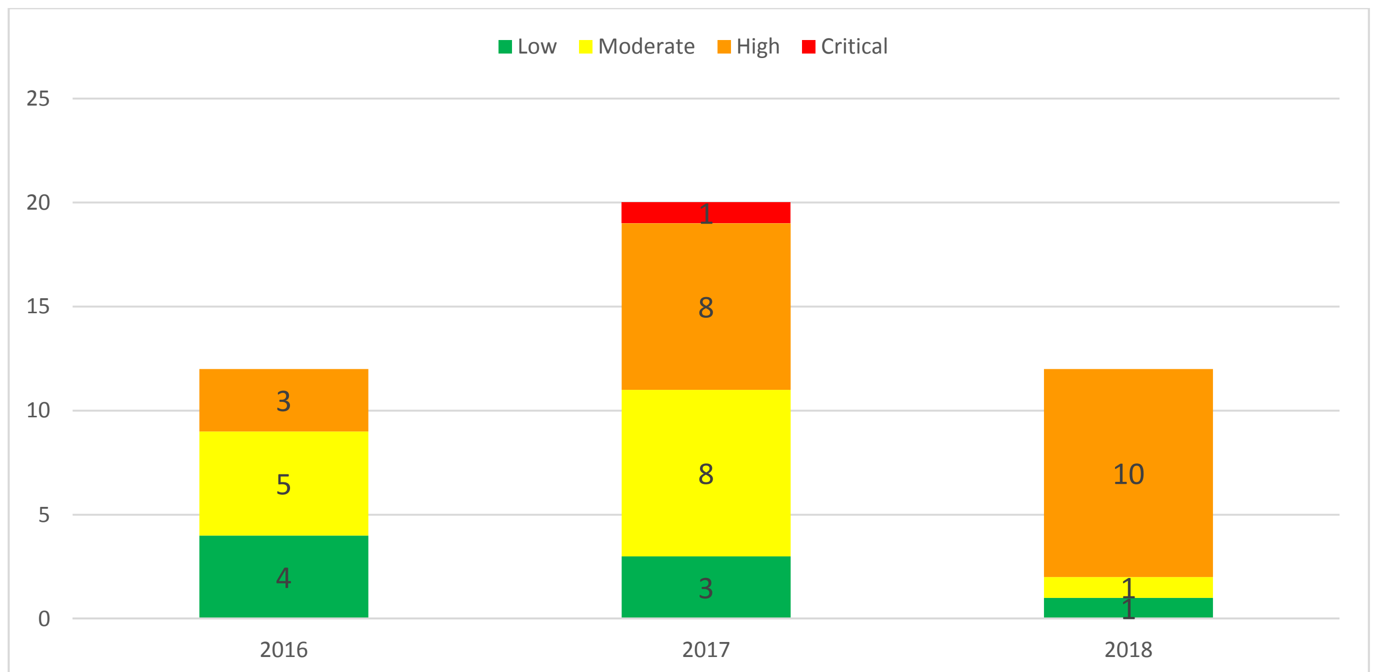
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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".

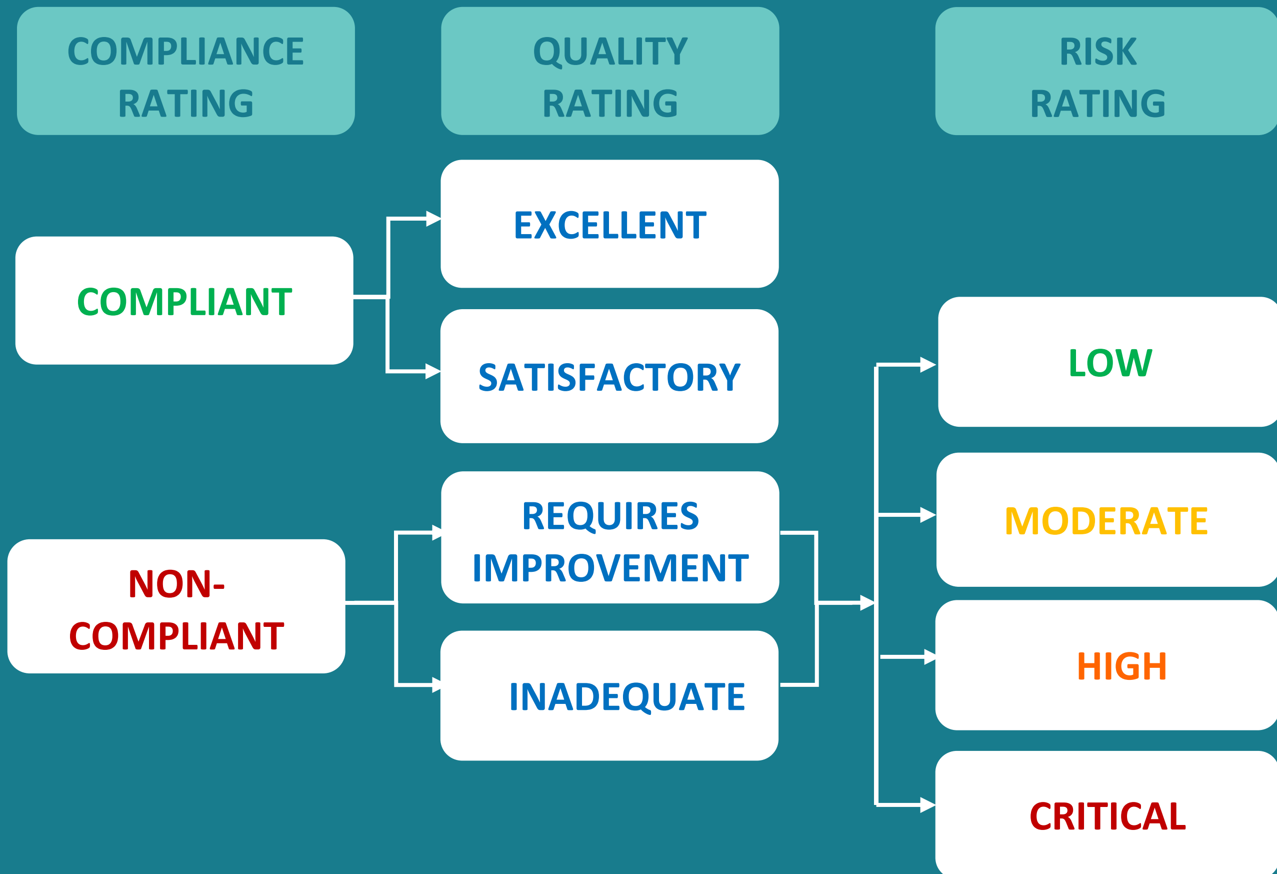
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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 – Summary 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 (DOP), Letterkenny, was the acute in-patient service for Donegal Mental Health Services. It was a modern, bright and spacious unit in Letterkenny University Hospital. It had 34 beds with a bed occupancy of 74% at the time of inspection.

There was a significant improvement in compliance in 2018 (49% in 2017 to 63% in 2018). There were eight regulations that had a quality rating of excellent. There was one condition to registration; the approved centre must audit their individual care plans on a monthly basis and provide a report on the results of the audits to the Mental Health Commission. The approved centre remained non-compliant with Regulation 15 Individual Care Plan.

Safety in the approved centre

Each resident had at least two personal identifiers. There was no evidence of regular food audits; however, hygiene was good in the kitchen areas.

There was no dedicated space for ''as required'' (PRN) medications on medication prescription, and administration records and PRN medication was prescribed with regular medication which increased the risk of a medication error. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, or management of aggression and violence. Structural risks, including ligature points, remained but were minimised. Work was ongoing at the time of the inspection in relation to minimising structural and ligature risks. Risk management policies did not detail arrangements for responding to emergencies, nor did they specify planned responses by the approved centre staff to possible emergencies, including evacuation procedures.

Appropriate care and treatment of residents

The approved centre had introduced a Family Liaison Nurse, based in the Department of Psychiatry, who worked with service users and their families. There was a condition to registration with regard to Individual care plans; however, despite some improvement, the approved centre remained non-compliant with

Regulation 15 Individual Care Plan. There was a satisfactory range of therapeutic activities which were linked to individual care plans and were evidence based. While there was access to physical assessment and treatment, six-monthly assessments were inadequate.

There were satisfactory admission procedures but discharge summaries for residents were not always completed with a fourteen day period.

Respect for residents' privacy, dignity and autonomy

Residents wore their own clothes and were only in nightclothes if indicated in their care plans. Private visiting facilities were available. Residents could access their own property within the approved centres. If a search of a resident was indicated it was carried out with due respect for the dignity of the resident and with two staff present.

Residents had access to their bedrooms during the day between 12md and 2pm only; otherwise, the doors were locked until 10pm. This was a restrictive practice and resulted in residents not being able to freely access their rooms or retire to bed early.

The noticeboard in the nursing office displayed the full names of residents, and as the noticeboard was visible from outside the glass, it was possible for other residents and members of the public to see residents' names on the noticeboard. This was a breach of confidentiality. CCTV was used in a manner that respected residents' privacy and dignity.

The approved centre was compliant with the Rule Governing the Use of Seclusion. However, it was not compliant with the Code of Practice on Physical Restraint: not all staff involved in physical restraint had read and understood the policy; one resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint; and in one case, the registered medical practitioner did not complete a physical examination of the resident within three hours after the start of an episode of physical restraint.

Responsiveness to residents' needs

The provision of meals and monitoring of nutritional status of residents were excellent. There was a wide range of appropriate and interesting recreational activities. Residents could freely communicate externally. A chaplain was available and residents could freely practice their religion if they wished. Adequate information was available for residents about the approved centre, their diagnosis and medication and the there was a robust complaints procedure in place.

The approved centre was not kept in a good state of repair externally. There was no programme of maintenance in relation to the outdoor areas, including the gardens and garden furniture. Staff brought in their own personal lawnmower to cut the grass. There were also areas internally that required urgent attention.

Governance of the approved centre

The approved centre was part of the Community Healthcare Organisation (CHO) 1, which included Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan Mental Health Services and was governed by Donegal area mental health management team. 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. Heads of discipline identified strategic goals for their staff and discussed potential operational risks with their departments, including difficulties in recruiting and retaining staff. The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders but the medication, health and safety, and staffing policies were not signed off or authorised by the governance group at the time of the inspection.

Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The person with responsibility for risk, the Acting Clinical Nurse Manager 3, was identified and known by all staff. 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. The ongoing monthly audits of individual care plans focusing on service user participation.

2. The development of the Donegal Suicide Prevention Strategy and its ongoing positive influence on families and staff in the approved centre particularly with regard to risk assessment training for staff.

3. The introduction of a Family Liaison Nurse based in the Department of Psychiatry working with service users and their families.

4. The engagement with Donegal Travellers Group to review strategies to support them in accessing services and to facilitate Traveller cultural training needs.

5. A wide range of professional development education and training programmes was offered to staff within the approved centre. These sessions were based on the approved centre's 2017/2018 training needs analysis.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Department of Psychiatry (DOP), Letterkenny, was the in-patient service for Donegal Mental Health Services. It was situated on the grounds of Letterkenny University Hospital. There was a modern reception and waiting area at the entrance of the approved centre. The unit was well signposted within the main hospital. The approved centre was bright and spacious and included colourful wall paintings which had been completed by past residents. The unit provided accommodation for 34 residents in a combination of four- and two-bed rooms and single rooms with en suites. The premises was generally well maintained, however there was no ongoing maintenance programme in place. The residents had access to internal gardens which were in need of maintenance at the time of inspection.

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

Resident Profile	
Number of registered beds	***34***
Total number of residents	**25**
Number of detained patients	2
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was part of the Community Healthcare Organisation (CHO) 1, which included Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan Mental Health Services and was governed by Donegal area mental health management team. Minutes from the monthly area management team meeting were available to the inspection team. Agenda items included the Mental Health Commission compliance, HR matters, CHO 1 Mental Health Operational Plan 2017, risk register, quality improvements, and budgets. The monthly Quality and Risk Management Group addressed risk management, Mental Health Commission compliance, corrective and preventative actions updates, and quality initiatives. Minutes from the monthly executive meeting were also available to the inspection team. Agenda items included Mental Health Commission inspection report, budgets, recruitment, complaints, and the CHO risk register.

The clinical director and the area director of nursing visited the approved centre at least weekly and the team leader for social work and the Occupational Therapy Manager visited at least once a fortnight. The Principal Psychologist was on leave at the time of inspection. 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. Heads of discipline identified strategic goals for their staff and discussed potential operational risks with their departments, including difficulties in recruiting and retaining 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. However, not all policies had been approved by the governance group.

4.5 Use of restrictive practices

Residents had access to their bedrooms during the day between 12md and 2pm only; otherwise, the doors were locked until 10pm. This was a restrictive practice and resulted in residents not being able to freely access their rooms or retire to bed early.

5.0 Compliance

5.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 15: Individual Care Plan	✗	High	✗	Critical	✗	High
Regulation 18: Transfer of Residents	✓		✗	Moderate	✗	High
Regulation 19: General Health	✓		✗	High	✗	High
Regulation 21: Privacy	✓		✗	Moderate	✗	Low
Regulation 22: Premises	✓		✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	Moderate	✗	Moderate	✗	High
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High
Regulation 28: Register of Residents	✓		✗	Low	✗	Moderate
Regulation 29: Operating Policies and Procedures	✓		✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✓		✗	High	✗	High
Code of Practice on the use of Physical Restraint in Approved Centres	✗	High	✗	Moderate	✗	High
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	Moderate	✗	Moderate	✗	High

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 5: Food and Nutrition
Regulation 7: Clothing
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 25: Use of Closed Circuit Television
Regulation 30: Mental Health Tribunals

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this Rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this Rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment 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.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.

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.

Three residents met with the assistant inspectors and provided insights into their experience in the approved centre. One resident interviewed also submitted a feedback letter. Six service user experience questionnaires were returned during the inspection process.

The residents were complimentary of the caring staff in the approved centre. Residents interviewed were involved in their care planning and had input into their care plans, if they so wished. One person interviewed expressed concern regarding clothes going missing within the unit; this was followed up by staff. 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 General Manager
- Executive Clinical Director (attended briefly)
- Acting Business Manager
- Acting Area Director of Nursing
- Occupational Therapy Manager
- Clinical Psychologist NHID
- Lead Social Worker
- Area Lead for Mental Health Engagement
- Acting Clinical Nurse Manager 3
- Clinical Nurse Manager 1
- Compliance, Quality & Patient Safety Nurse Manager

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.

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 April 2015. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Arrangements were in place which ensured that each resident was readily identifiable by staff. A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. The identifiers, detailed in residents' clinical files, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The identifiers used were person-specific, and appropriate to the residents' communication abilities. There was a yellow sticker alert system in place on clinical files to help staff in distinguishing between residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

(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 July 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policies. 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 the general hospital dietitian in consultation with catering staff, to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was attractively presented. The texture and flavour of food was appealing. Hot meals were served daily.

A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Hot and cold drinks were offered to residents regularly. In relation to residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Their special dietary needs were regularly reviewed by a dietician and an evidence-based nutrition assessment tool, 'The Malnutrition Universal Screening Tool' was used.

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

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had/did not have up-to-date training in food safety commensurate with their role, and evidence of certification was not routinely available.

Monitoring: There was no documented evidence to indicate that 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 processes.

Evidence of Implementation: There was suitable and sufficient catering equipment in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Food was prepared in the general hospital kitchen, which was then transported to the approved centre on a cook-chill basis. The risk of contamination, spoilage, and infection was reduced in the preparation of food. 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 training and education and monitoring pillars.

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 July 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 a weekly basis. No current residents were prescribed to wear night clothes during the day.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were encouraged to send laundry home, or they could avail of a self-paid laundry service daily, through Kelly laundry services who laundered clothes off-site.

There was no washing machine or dryer available in the approved centre. In cases where the resident was involuntary, the approved centre paid for their clothes to be laundered. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, religious, and cultural practices. Residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was 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 2015. 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 not monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

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

Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

Monies over €200 were sent to the general office. Smaller cash amounts were retained in the safe in nursing office. The access to and use of resident monies was overseen by two members of staff, but residents did not always countersign while accessing their own monies through staff.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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 June 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents were provided with detailed, accessible, and user-friendly information on recreational activities, including the type and frequency of recreational activities. A programme of indoor and outdoor activities was drawn up each Monday morning which incorporated residents' preferences.

Recreational activities provided included table tennis, a light exercise class, football, outdoor exercise including arranged walks, outings, and the use of the town park nearby. There was a baking group, books to read, DVDs to watch, arts and crafts, knitting, make up sessions, a hairdresser, and manicures. Communal areas were suitable for recreational activities. Documented records of attendance were retained for recreational activities groups' records, or within the resident's clinical file, as appropriate. If the resident left an exercise class early, this was also documented.

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 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. The policy was last reviewed in June 2016. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 their religion were facilitated and supported within the approved centre, in a reasonably practicable manner. Mass was held once a week on-site. Residents could go to daily Mass in Letterkenny Hospital, and to Sunday Mass in St. Conal's Church.

Residents had access to multi-faith chaplains, by contacting the chaplain in the main hospital. The chaplain then arranged for the relevant person to call, such as the Church of Ireland Minister. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was 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 in relation to visits, which was last reviewed in June 2017. The policy included 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: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed at the entrance of the approved centre, and throughout the unit. Separate dedicated visitors' rooms and visiting areas were 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. There was no visiting restriction implemented for any resident at the time of the inspection.

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

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in May 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the assessment of resident communication needs.

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: No current residents had restrictions on their communication. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: There were no restrictions on residents' communications at the time of the inspection. Residents could use mail, fax, and telephone if they wished. Residents retained their own mobile phones. Residents could access the internet through their personal devices only; there was no Wi-Fi in the approved centre.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches, which was last reviewed in September 2017. The policy addressed 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.

The policy did not include the processes for communicating the approved centre's search policies and procedures to residents and staff.

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 searching processes, as set out in the policy.

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis had 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. The clinical file of one resident who was searched was

inspected. Risk had been assessed prior to the search of the resident, and their property, appropriate to the type of search being undertaken. The resident's consent was sought and documented.

The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident's dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

A written record of every search of a resident, environmental search, and property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written operational policies in relation to care of the dying. The first was entitled ‘Care of the dying in the approved centre’ and was last reviewed in May 2017; the second policy was titled ‘In the event of an unexpected death in the approved centre’, and was last reviewed in June 2017’. The policies combined addressed all of the requirements of the *Judgement Support Framework*.

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

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

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

Evidence of Implementation: Each resident had an individual care plan, and ten were reviewed on inspection. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Residents had been assessed at admission by the admitting clinician and an ICP was completed to address the immediate needs of the resident. All residents received an evidenced-based comprehensive assessment by the MDT within seven days of admission. There were two disciplines which comprised the MDT; nursing and medical.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. ICPs identified the resident's assessed needs, was a documented set of appropriate goals for each resident, and specified the treatment and care required.

Not all ICPs identified necessary resources, including specific relevant disciplines. Many ICPs cited nursing or medical staff. One ICP was blank under resources required. Three ICPs stated MDT, and not a specific discipline.

ICPs were developed, regularly reviewed, and updated by the resident's MDT, with the exception of one ICP inspected which had not been reviewed by the MDT for three weeks. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews.

A designated key worker was not consistently identified to ensure continuity in the implementation of a resident's ICP. The key worker was identified as the consultant psychiatrist. In effect, it was the primary nurse associated with that named consultant who was the key worker for the particular day, and not the consultant psychiatrist.

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

a) **One ICP had not been reviewed by the MDT for three weeks.**
b) **ICPs did not adequately identify the resources required.**

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 September 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The range of services and programmes provided in the approved centre was not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents. All the therapeutic programmes and services were provided by staff trained in accordance with their care delivery roles. These programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. The programmes were co-ordinated and facilitated by nursing staff. An occupational therapist facilitated one group a week, and there was a full time social worker available within the approved centre. Allied health professionals from the respective community and consultant led teams, met with residents as required on a one to one basis. An occupational therapist position was recently vacant, and the position was been handled by the national recruitment service at the time of the inspection.

Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies. A record was maintained of participants, engagement, and outcomes achieved in therapeutic services or programmes within each resident's clinical file.

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

Regulation 18: Transfer of Residents

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

(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 June 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 been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had 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 in an acute medical emergency situation, was examined. 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, including the reasons for transfer. The resident's accompaniment requirements on transfer was not documented.

The resident was physically assessed prior to the transfer, but there was no risk assessment documented in relation to the transfer. Written information was issued as part of the transfer, including a letter of referral. There was no evidence to show that the resident transfer form was completed. A copy of the letter of referral and the resident transfer form was not retained in the resident's clinical file.

A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. No copies of records relevant to the transfer process were retained in the resident's clinical file.

The approved centre was non-compliant with this regulation because there was no evidence in the form to indicate that all relevant information about the resident was provided to the receiving health care facility, 18 (1).

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. The general health policy was last reviewed in May 2018. The medical emergencies policy was last reviewed in November 2017. The policies and procedures 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 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, where applicable. 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: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator. The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, and residents received a six-monthly general health assessment.

One six-monthly general health assessment file inspected documented a physical examination, the resident's blood pressure and a medication review (per prescriber guidelines). It did not document family/personal history, Body Mass Index, weight, waist circumference, smoking status, nutritional status (diet and physical activity, including sedentary lifestyle), or dental health.

For residents on antipsychotic medication, glucose regulation, blood lipids, electrocardiogram, and prolactin levels were not documented or monitored.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing.

The approved centre applied the HSE national policy on tobacco use. At the time of the inspection there was no resident being supported to stop smoking. There was a smoking cessation officer available within Letterkenny University Hospital, who could attend the approved centre by request. The smoking cessation officer could prescribe nicotine replacement therapy and a smoking cessation programme by request. The smoking cessation officer also facilitated the handover to community support services.

The approved centre was non-compliant with this regulation due to the failure to ensure that all six monthly reviews fulfilled the criteria stipulated by the Mental Health Commission, 19, 1 (b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents, which was last reviewed in April 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for identifying residents' preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.
- The interpreter and translation services available within the approved centre.
- The process for managing the provision of information to residents' representatives, family, and next of kin, as appropriate.
- The advocacy arrangements.

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

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents, their families, and carers, were provided with a booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and arrangements, and relevant advocacy and voluntary agencies details. Details of residents' rights were not addressed in the handbook. 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. At the time of the inspection, there were no restrictions on information regarding a resident’s diagnosis applied to any resident.

Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. 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 when needed.

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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 June 2017. 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.

Evidence of Implementation: The general behaviour of staff and the way in which staff interacted with residents was respectful. Residents were appropriately dressed to ensure their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Rooms were not overlooked by public areas.

Residents' privacy was not appropriately respected at all times. The noticeboard in the nursing office displayed the full names of residents, and the noticeboard was visible from outside the glass. It was possible for other residents and members of the public to see residents' names on the noticeboard. While observation panels on doors of treatment rooms and bedrooms were fitted with blinds, it was not possible to open and close many of the blinds due to the fact that the blind rod was absent from observation panel screens.

Residents were facilitated to make private phone calls through the public phone box.

The approved centre was non-compliant with this regulation because the noticeboard in the nursing office displayed resident names in full, and this did not ensure that residents' privacy was appropriately respected 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 July 2017. The policy addressed 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 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: Accommodation for each resident ensured their comfort and privacy and met their assessed needs. All bedrooms had en suite facilities, and were appropriately sized to match residents' needs. There was a sufficient number of accessible and clearly marked toilets and showers for residents, which were located close to day and dining areas.

There were adequate and suitable furnishings. The approved centre provided appropriately sized communal rooms. It was adequately lit, heated, and ventilated. Heating could be safely controlled in the resident's own room. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities.

There was no rod to open or close the blinds on observation panel screens on doors of treatment rooms and bedrooms. Ligature points were evidenced in bathrooms, but overall ligature points were minimised. Hazards were not minimised. There was a trip hazard in one of the bedrooms, with the floor covering lifting due to a broken seal and water damage, and a resident could potentially catch their foot and trip. There was a leak in the wall in one of the bedrooms which resulted in damp patches and chipped paint.

In addition, a headboard had been defaced in one bedroom and a sink in another, neither of which had been reported to the maintenance department.

The approved centre was not kept in a good state of repair externally. There was no programme of maintenance in relation to the outdoor areas, including the gardens and garden furniture. Staff brought in their own personal lawnmower to cut the grass. There was a programme for painting and cleaning, and a cleaning schedule was implemented. Not all damage to property had been reported to the maintenance department for repair.

The approved centre was not free from offensive odours. There was a lingering smell in the bathroom and bedroom from the flooring lifting. Sufficient spaces were provided for residents to move about, including outdoor spaces. Remote or isolated areas of the approved centre were monitored, and back-up power was available to the approved centre.

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

a) There was no programme of maintenance for the garden and outdoor areas, and not all damage to property had been reported to the maintenance department, 22, 1 (c).
b) Hazards and ligature points were not minimised. This did not show due regard to the safety and well-being of the residents, 22 (3)

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication; one policy was last reviewed in June 2017, and the second policy was last reviewed in May 2018. The policies included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for self-administration of medication.
- The process for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.

Training and Education: Not all 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. 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, and ten of these were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, allergy status, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR. Three MPARs did not record the date of discontinuation for each medication.

However, MPARs did not address the generic name of the medication and preparation. In addition, there was no dedicated space for ''as required'' (PRN) medications on MPARs. As a result the doctors were prescribing the ''as required'' (PRN) medication with the regular medication. PRNs were also written in the sliding scale section of the MPAR.

All entries in the MPAR were legible and written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration; and expired medications were not administered. Medication was

reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition. This was documented in the resident's clinical file.

All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members prior to administration. The use of appropriate resident identifiers, good hand-hygiene techniques, and cross-infection control techniques were observed during the administration of medication.

Medication was stored in the appropriate environment, as advised by the pharmacist. Refrigerators used for medication were used only for this purpose and no food or drink was stored alongside medication. A log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis, checking the name, dose, and quantity of medication, and expiry date.

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 section 1 of this regulation because:

a) **Three MPARs did not record the date of discontinuation for each medication.**
b) **There was no dedicated space for ''as required'' (PRN) medications on MPARs. PRN or ''as required'' medication was prescribed with regular medication.**

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 written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in June 2017. That safety statement was last reviewed in January 2018. The policy and safety statement combined 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 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 **Excellent**

(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 October 2016. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The CCTV equipment was checked regularly to ensure it was operating effectively. This was documented. Analysis had 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. Residents were monitored solely for the purposes of ensuring his/her health, safety, and welfare. CCTV was used in the seclusion facility, and in areas that were monitored for security purposes. The usage of CCTV had been disclosed to the Mental Health Commission. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form. CCTV cameras used to observe a resident did not transmit images other than to a monitor that is viewed solely by the health professional responsible for the resident.

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 26: Staffing

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	HIGH

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements, which was last reviewed in July 2017. The policy and procedures addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The job description requirements.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The process for transferring responsibility from one staff member to another.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan 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 been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place which 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.

Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was delivered by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training. Training took place in the approved centre. Staff also had access to training were appropriate in the general hospital, which was on campus.

The number and skill mix of staffing were sufficient to meet resident needs. A written staffing plan was not available within the approved centre. Staff were trained in manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management, and treatment, incident reporting, the protection of children and vulnerable adults, and the Mental Health Act 2001.

Staff were not trained in children first or recovery-centred approaches to mental health care. There was no documentary evidence of training records for medical staff provided to the inspection team. Training records were provided for nursing staff. Not all health care staff were trained in the following:

- Fire safety
- Basic Life Support
- The Professional Management of Aggression and Violence

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Department of Psychiatry Letterkenny University Hospital	CNM3	1	1
	CNM1	1	0
	RPN	12-13	6
	HCA	0	0
	Occupational Therapist	2 hours/week	0
	Social Worker	1	0
	Psychologist	2 days/week	0
	Dietitian	By referral	0
	Speech&Language Therapist	By referral	0

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

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

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy, a guideline document, and procedures in relation to the maintenance of records. The guideline document was last reviewed in December 2017. The policy on the management of inpatient healthcare records did not have a revision date. The policy and guideline document combined addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Record review requirements.
- Privacy and confidentiality of resident record and content.
- The process for making a retrospective entry in residents' records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were not included in the review process. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Resident records were reflective of the residents' current status and the care and treatment being provided. Records had no loose pages. Resident records were physically stored together. All residents' records were secure, up to date, constructed, maintained, and used in accordance with national guidelines and legislative requirements. Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident.

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

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre. Records were retained/destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Clinical files were stored for two years post discharge in a designated area. Admin, the nurse in charge, and doctor kept the key. After two years, files were transported to a Health Service Executive storage area off site, where files could be accessed if required.

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, training and education, and monitoring pillars.

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating **MODERATE**

(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 register of residents admitted. The register was not up-to-date. The register contained the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006 with two exceptions: the register of residents was not up-to-date, and the diagnosis on discharge was not consistently recorded.

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

a) **The register was not up-to-date, 28 (1).**
b) **The register did not include all of the information specified in Schedule 1 to these Regulations: diagnosis on discharge was not recorded for all residents, 28 (2).**

Regulation 29: Operating Policies and Procedures

NON-COMPLIANT

Quality Rating **Requires Improvement**
Risk Rating **HIGH**

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 September 2017. The policy was not authorised by the governance group. It 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. The operating policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines. Operating policies and procedures were communicated to all relevant staff.

The operating policies and procedures required by the regulations were not all reviewed or appropriately approved within the required three-year timeframe. Specifically, the medication, health and safety, and staffing policies were not signed off or authorised by the governance group at the time of the inspection.

While the format of the operating policies and procedures was standardised, the format did not identify policy approvers. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

The approved centre was non-compliant with this regulation because not all policies required by this regulation had been authorised.

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

(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 February 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 could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

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

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. Staff attended Mental Health Tribunals 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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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 December 2017. The policy and procedures partially addressed requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

The policy did not detail:

- The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.
- The timeframes for complaint management, including the timeframe for the approved centre to respond to the complaint and for the complaint to be resolved.
- The documentation of complaints, including the maintenance of a complaints log by the nominated person.
- The communication of the complaints policy and procedure with residents, their representatives, family and next of kin, and visitors.

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 been completed. Audits were documented and the findings were acted upon. Complaints data was analysed.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed in the nursing station, and it was detailed within the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, 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. The approved centre had access to advocacy through the local STEER Advocacy Services. All complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the compliant.

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

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

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 clinical risk management policy was last reviewed in March 2016. The policies combined partially addressed requirements of the *Judgement Support Framework*, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring risks throughout the approved centre, including; health and safety risks to residents, staff, and visitors; risks to the resident group during the provision of general care and services, and risks to individual residents during the delivery of individualised care.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The policies did not address the following:

- The process for identification, assessment, treatment, reporting, and monitoring of organisational, structural, ligature, and capacity risks throughout the approved centre.
- The roles and responsibilities of key staff.
- The sequence of required actions.
- The process for communication.
- The escalation of emergencies management.
- The process for maintaining and reviewing the risk register.

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

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

Evidence of Implementation: Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. The person with responsibility for risk, the Acting Clinical Nurse Manager 3, was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

There was no emergency plan in place that addressed responses by the approved centre's staff in relation to possible emergencies, including evacuation procedures.

Clinical, health and safety, and corporate risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at resident admission, transfer, and discharge, prior to episodes of resident seclusion, physical restraint, and specialised treatments such as electro-convulsive therapy, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Neither residents nor their representatives were not involved in individual risk management processes.

Structural risks, including ligature points, remained but were minimised. Work was ongoing at the time of the inspection in relation to minimising structural and ligature risks. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. Information provided was anonymous at resident level.

The approved centre was non-compliant with this because the risk management policies did not detail arrangements for responding to emergencies, nor did they specify planned responses by the approved centre staff to possible emergencies, including evacuation procedures, 32,2 (e).

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 main foyer.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Patients in seclusion had access to adequate toilet and washing facilities in the bathroom opposite the seclusion room. All uses of seclusion were clearly recorded in the clinical files and on the seclusion register. In all episodes of seclusion inspected, patients were informed of the ending of seclusion and the reasons for ending seclusion were recorded in the clinical files. Each episode of seclusion was reviewed by the multi-disciplinary team, and documented in the clinical file within two working days after the episode of seclusion.

The approved centre was compliant with this rule.

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

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

Quality Rating	Requires Improvement
Risk Rating	HIGH

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 May 2017. The policy addressed the following:

- The provision of information to the resident.
- Those who can initiate and implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: Not all staff involved in physical restraint had signed 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 were reviewed. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all cases, the restraint order lasted for a maximum of 30 minutes.

In one case, the registered medical practitioner did not complete a physical examination of the resident within three hours after the start of an episode of physical restraint. One resident out was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing them were not documented. In one case, the resident's next of kin was not informed about the physical restraint and the reasons for not informing them were not documented.

Cultural awareness and gender sensitivity was demonstrated in the three episodes of physical restraint. Each episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT), and documented in the clinical file no later than two working days after the episode. All residents were afforded the opportunity to discuss the episode with members of the MDT as soon as was practicable. All uses of physical restraint were clearly recorded in the clinical practice forms detailed and recorded within clinical files.

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

a) Not all staff involved in physical restraint had signed to indicate that they had read and understood the policy, 9.2 (b).
b) One resident out of three was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint, and no explanation for not informing the resident was documented, 5.8.
c) In one case the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented, 5.9 (a).

d) In one case, the registered medical practitioner did not complete a physical examination of the resident within three hours after the start of an episode of physical restraint, 5.4.

Admission, Transfer and Discharge

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	HIGH

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. Each policy was last reviewed in June 2017. The policies combined included all of the policy-related criteria for this 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, transfer, and discharge policies.

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 health illness or mental disorder. The decision to admit was made by the registered medical practitioner or Consultant Psychiatrist. The resident was assigned a key worker. The resident had received an admission assessment. The resident's family member/carer/advocate were involved in the admission process, with the resident's consent. The admission assessment was completed; and it included presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, 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 was non-compliant with Regulation 18: Transfer of Residents.

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

There was appropriate MDT input into discharge planning. A preliminary discharge summary was sent to the primary care within three days. A comprehensive discharge summary was not issued within the stipulated timeframe of 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse. A timely follow up appointment with the resident following discharge was documented.

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

a) **The approved centre was non-compliant with Regulation 18: Transfer of Residents, 30.1.**
b) **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.**
c) **In relation to the resident who was discharged, a comprehensive discharge summary was not issued within 14 days, 38.3 (b).**

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan

Report reference: Page 29 & 30

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1], new[2] area of non-compliance, or monitor as per condition[3]*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. One ICP had not been reviewed by the MDT for three weeks. 2. ICPs did not adequately identify the resources required.	*Monitor as per condition*				

[1] Area of non-compliance reoccurring from 2017

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

[3] To ensure adherence to *Regulation 15: Individual Care Plan*, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

Regulation 18: Transfer of Residents

Report reference: Page 32

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
3. There was no evidence in the form to indicate that all relevant information about the resident was provided to the receiving health care facility, 18 (1).	Reoccurring	Corrective Action(s):Memo/Email to be issued to all staff to copy transfer documentation and retain in clinical file in the interim while awaiting Transfer book. Post-Holder(s) responsible:ADON/ECD	Review and audit of clinical file/AC Transfer Log	Completed	08/11/2018
		Preventative Action(s): Transfer form to go to print to be made as carbon copy book with requirements of the Code of Practice Post-Holder(s) responsible: ADON/ECD	Purchase Order	None	21st Dec 2018

Regulation 19: General Health

Report reference: Page 33 & 34

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
4. Failure to ensure that all assessments fulfilled the complete criteria stipulated by the Mental Health Commission, 19, 1 (b). Specifically, the assessments did not document family/personal history, Body Mass Index, weight, waist circumference, smoking status, nutritional status (diet and physical activity, including sedentary lifestyle), or dental health. For residents on antipsychotic medication, glucose regulation, blood lipids, electrocardiogram, and prolactin levels were not documented or monitored.	*New*	Corrective Action(s):DMHS is piloting a new model of physical care assessment as part of the National working Group on Physical Health Post-Holder(s) responsible:Physical Health National Steering Group/ECD	National Group will monitor the implementaion	Achievable (Project ongoing for next 6-12 months)	Working group commenced review of clinical files on 25/10/2018
		Preventative Action(s): All Clinical staff required to participate in MECC training as part of improving compliance with requiremets of Reg 19 General Health Post-Holder(s) responsible:	Record of Participation	Achievable	Training is planned for 2019

Regulation 21: Privacy

Report reference: Page 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
5. The noticeboard in the nursing office displayed resident names in full, and this did not ensure that residents' privacy was appropriately respected at all times.	*New*	Corrective Action(s):Confidential Winged Magnetic white boards ordered for both female and male units Post-Holder(s) responsible:ADON/CNM3	Purchase order and installation of new white boards	Achievable	09/11/18
		Preventative Action(s): Winged door will be closed over to prevent disclosure of confidential information when board is not in use Post-Holder(s) responsible: All clinical staff	Observation	Achievable	30/11/18

Regulation 22: Premises

Report reference: Page 38 & 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
6. There was no programme of maintenance for the garden and outdoor areas, and not all damage to property had been reported to the maintenance department, 22, 1 (c).	*New*	Corrective Action(s):Programme of works to be drawn up and tenders sought for external providers Programme of outdoor maintenance to be intitiated and maintained by business office Post-Holder(s) responsible:Business manager	Tendering process as per HSE policy Review and audit of maintenance programme/ Quarterly walkabout by Maintenance foreman; Domestic Supervisor; Business Mangaer & ADON/CNM3	Achievable	21st December
		Preventative Action(s): Adherence to the programme of works Quarterly walkabout of AC to review premises and review of works completed or due for completion Post-Holder(s) responsible:Business Manager	Review and audit of the programme of works Quarterly walkabout by Maintenance foreman; Domestic Supervisor; Business Mangaer & ADON/CNM3	Achievable	29/01/2019 30/04/2019 23/07/2019 22/10/2019
7. Hazards and ligature points were not minimised. This did not show due regard to the safety and well-being of the residents, 22 (3)	*Reoccurring*	Corrective Action(s): Programme of works has been put in place in response to ligature audit/hazards identified Quotes currently being sought for repair of works Post-Holder(s) responsible: Business Manager/Maintenance foreman/ADON	Programme of works Purchase order/Tendering Process as per HSE policy Ligature Audit/Quarterly Walkabout	Acheivable	Scheduled for completion in 2019

		Preventative Action(s): Quarterly walkabout of AC to review premises and review of works completed or due for completion Post-Holder(s) responsible: Business Manager/Maintenance foreman/ADON	Quarterly walkabout by Maintenance Manager; Domestic Supervisor; Business Mangaer & ADON/CNM3	None	29/01/2019 30/04/2019 23/07/2019 22/10/2019

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

Report reference: Page 40 & 41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
8. Three MPARs did not record the date of discontinuation for each medication.	*New*	Corrective Action(s):ECD put as a standing order on the agenda for Consultants meeting and NCHD post grad training. Post-Holder(s) responsible:ECD	Minutes of meetings	Achievable	Teaching occurs every Monday afternoon
		Preventative Action(s): Review results of MPAR's audit and audit findings for discussion and action planning at medical teaching Post-Holder(s) responsible: ECD	Clincial tutor to include in post grad teaching	Achievable	Ongoing
9. There was no dedicated space for ''as required'' medications on MPARs. "As required" medication was prescribed with regular medication.	*New*	Corrective Action(s): New MPAR's booklet to be introduced to Approved Centre Post-Holder(s) responsible: ECD/ADON	Purchase order and introduction of new MPAR's	Achievable	31/01/2019
		Preventative Action(s): Implementation of new MPAR's document Post-Holder(s) responsible: ECD	Quarterly Audit of MPAR's for compliance	Achievable	31/01/2019

Regulation 26: Staffing

Report reference: Page 44 & 45

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
10. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety and the Professional Management of Aggression and Violence, 26(4).	*Reoccurring*	Corrective Action(s):All line managers to ensure staff compliant with mandatory training as identified in staff training plan Post-Holder(s) responsible:All Heads of Discipline	Quarterly monitoring and review of training plans by HoD's	Availabitlity of staff for mandatory training is problematic due to release and backfill and may be problematic for case load managment	09/01/2019 03/04/2019 03/07/2019 03/10/2019
		Preventative Action(s): Quarterly audit of Training Plan and staff compliance rates Post-Holder(s) responsible: All Heads of Discipline	Quarterly Review and Audit of Training Plans by HoD's	Availabitlity of staff for mandatory training is problematic due to release and backfill and may be problematic for case load managment	09/01/2019 03/04/2019 03/07/2019 03/10/2019

Regulation 28: Register of Residents

Report reference: Page 48

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
11. The register was not up-to-date, 28 (1). 12. The register did not include all of the information specified in Schedule 1 to these Regulations: diagnosis on discharge was not recorded for all residents, 28 (2).	New	Corrective Action(s) (12) ECD to put memo to NCHD's and Consultants to ensure compliance with register requirements Post-Holder(s) responsible:ECD	Memo	Achievable	10/12/2018
		Preventative Action(s): Clinical supervision of NCHD's by Supervising consultants MHA to liaise with consultants Post-Holder(s) responsible:ECD	MHA to review and monitor clinical file on Discharge	Achievable	Ongoing

Regulation 29: Operating Policies and Procedures

Report reference: Page 49

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
13. Not all policies required by this regulation had been authorised. Specifically, the medication, health and safety, and staffing policies were not signed off or authorised by the governance group at the time of the inspection	New	Corrective Action(s): All polocies have been signed off by DMHS governance group Post-Holder(s) responsible:DMHS PPPG group	Review of Signature sign off	Completed	13/11/2018
		Preventative Action(s): Policy Portal System to be installed. This will generate renewal dates for policies to be reviewed and updated and ensure prompt sign off by governance group. Governance Group chair has been replaced by the Area Management Team Post-Holder(s) responsible: DMHS PPPG group	Review and audit of Policies	Portal installed All DMHS Policies to be uploaded to system, all staff to be trained by 5th February 2019	14 December 2018 10 January 2019

Regulation 32: Risk Management Procedures

Report reference: Page 53 & 54

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
14. The risk management policies did not detail arrangements for responding to emergencies, nor did they specify planned responses by the approved centre staff to possible emergencies; including evacuation procedures, 32, 2 (e).	New	Corrective Action(s):Policy to be reviewed and amended to include the requirements under 32,2(e) Post-Holder(s) responsible:DMHS PPPG group	Review and audit against the JSF	Achievable	31/01/2019
		Preventative Action(s): (1)All Policies to be reviewed against the JSF (2)Arrangements for emergency evacuations to be inserted into Risk Management Policy Post-Holder(s) responsible: DMHS PPPG group	Review and audit against the JSF	Achievable	(1) 09/01/2019 03/04/2019 03/07/2019 03/10/2019 (2) 31/01/2019

Code of Practice: Use of Physical Restraint

Report reference: Page 61 & 62

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
15. Not all staff involved in physical restraint had signed to indicate that they had read and understood the policy, 9.2 (b).	*Reoccurring*	Corrective Action(s): MAPS Electronic Policy Portal to be installed. This will generate an email to all relevant staff to read a policy and ensure policy signoff. Post-Holder(s) responsible: Heads of Discipline	Review and Audit of electronic system	Portal installed All DMHS Policies to be uploaded to system, all staff to be trained by 5th February 2019	14 December 2018 10 January 2019
		Preventative Action(s): Governance of staff signoff of policy Policy Portal will generate signature report to each HoD and line manager will ensure compliance from their staff Post-Holder(s) responsible:Heads of Discipline	Portal administrator will Review and audit signature report and send same to HoD's quarterly	None	29/01/2019 30/04/2019 23/07/2019 22/10/2019
16. One resident out of three was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint, and no explanation for not informing the resident was documented, 5.8.	*Reoccurring*	Corrective Action(s): Post restraint checklist has been introduced to meet the requirements and standards set out in the Code of Practice and is being completed by clinical staff involved in restraint CNM2 to deliver short briefing sessions on restraint to clinical staff Post-Holder(s) responsible: CNM2	Quarterly Review and Audit of Code of Practice on Use of Physical Restraint Teaching sessions	Achievable	31/08/2018

		Preventative Action(s): Implementation of Post restraint checklist Teachings sessions with clinical staff Post-Holder(s) responsible: CNM2	Review and Audit of Clinical files against Code of Practice on Use of Physical Restraint	Achievable	09/01/2019 03/04/2019 03/07/2019 03/10/2019
17. In one case the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented, 5.9 (a).	*Reoccurring*	Corrective Action(s): Post restraint checklist to be introduced to meet the requirements and standards set out in the Code of Practice and to be completed by clinical staff involved in the restraint CNM2 to deliver short briefing sessions on restraint to clinical staff Post-Holder(s) responsible:CNM2	Review and Audit of Clincial files against Code of Practice on Use of Physical Restraint Teaching sessions	Achievable	31/08/2018
		Preventative Action(s): Implementation of Post restraint checklist Post-Holder(s) responsible: CNM2	Review and Audit of Code of Practice on Use of Physical Restraint	Achievable	09/01/2019 03/04/2019 03/07/2019 03/10/2019
18. In one case the registered medical practitioner did not complete a physical examination of the resident within three hours after the start of an episode of physical restraint, 5.4.	*Reoccurring*	Corrective Action(s): ECD to issue to memo to NCHD's to document in clinical file reason for not meeting time frame Post restraint checklist to be introduced to meet the requirements and standards set out in the Code of Practice and to be completed by clinical staff involved in the restraint Post-Holder(s) responsible: ECD/CNM2	Memo Quarterly Review and Audit of Clincial files against Code of Practice on Use of Physical Restraint	Achievable within work load parameters	Memo 10/12/2018 Quarterly Audit 2019 09/01/2019 03/04/2019 03/07/2019 03/10/2019

		Preventative Action(s): Implementation of Post restraint checklist Memo Post-Holder(s) responsible: ECD/CNM2	Review and Audit of Code of Practice on Use of Physical Restraint	Achievable	Quarterly 2019 09/01/2019 03/04/2019 03/07/2019 03/10/2019

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 63 & 64

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
19. 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.	*Reoccurring*	Corrective Action(s): MAPS Electronic Policy Portal to be installed. This will generate an email to all relevant staff to read a policy and ensure policy signoff. Post-Holder(s) responsible: Heads of Discipline	Review and Audit of electronic system	Portal installed All DMHS Policies to be uploaded to system, all staff to be trained by 5th February 2019	14 December 2018 10 January 2019
		Preventative Action(s): Governance of staff signoff of policy Policy Portal will generate signature report to each HoD and line manager will ensure compliance from their staff Post-Holder(s) responsible:Heads of Discipline	Portal administrator will Review and audit signature report and send same to HoD's quarterly	Achievable	29/01/2019 30/04/2019 23/07/2019 22/10/2019
20. In relation to the resident who was discharged, a comprehensive discharge summary was not issued within 14 days, 38.3 (b).	*New*	Corrective Action(s): Temporary Admin relief was provided to cover leave and manage backlog Post-Holder(s) responsible:Business Manager	Temporary filling of post	Reassignmnet of admin duties when unplanned leave occurs	27/08/2018
		Preventative Action(s): Comprehensive handwritten summary is faxed within 14 days to CMHT/GP Post-Holder(s) responsible:Business Manager	Fax record in clinical file	Achievable	Ongoing