Department of Psychiatry, Roscommon University Hospital

ID Number: AC0011

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry,
Roscommon University Hospital
Athlone Road
Roscommon
Co Roscommon

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

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

Inspection Team:
Mary Connellan, Lead Inspector
Siobhán Dinan
Elaine Healy
Karen McCrohan

Inspection Date:
20 – 23 August 2018

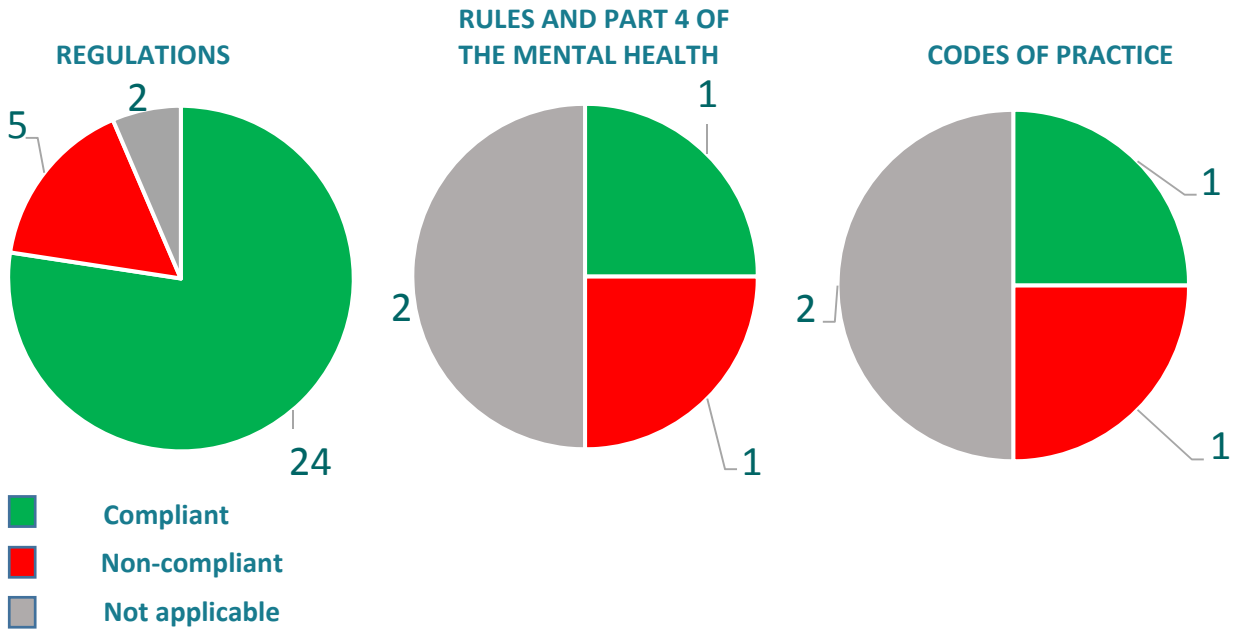
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
5 – 8 September 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
17 January 2019

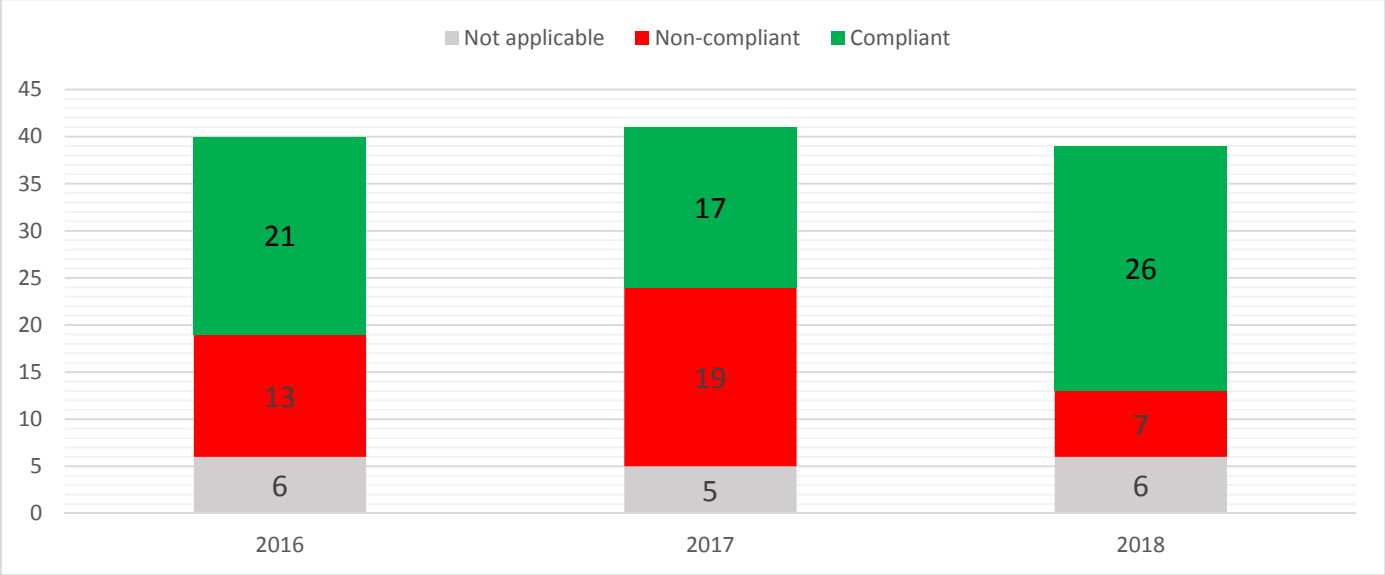
2018 COMPLIANCE RATINGS



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

Contents

1.0 Introduction to the Inspection Process

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

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

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

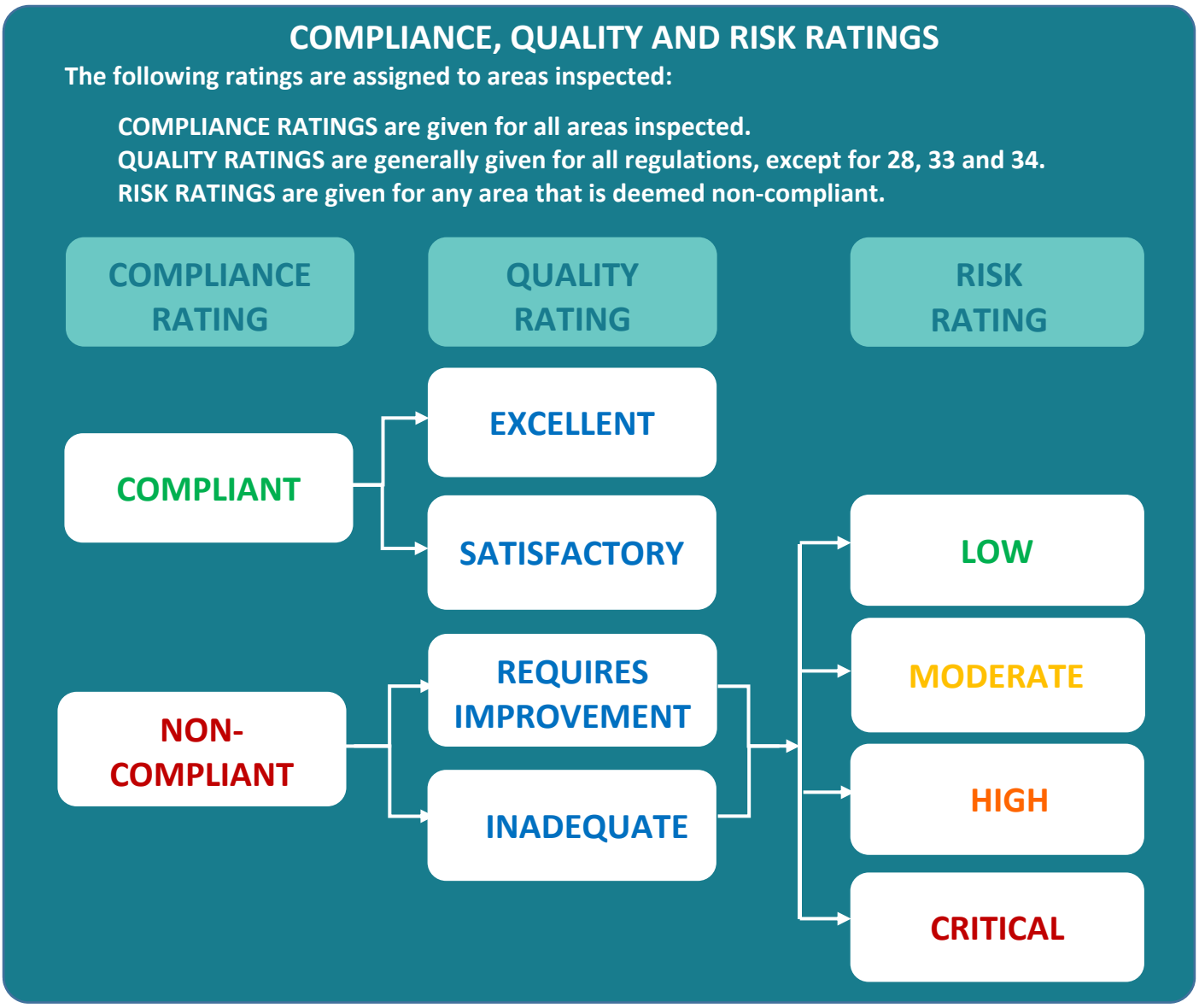
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The approved centre provided an acute psychiatric service. It was located on the ground floor of Roscommon University Hospital and was registered for 22 beds. A sensory garden had opened since the previous inspection and was available to residents throughout the day and early evening. Phase one of a refurbishment plan had been completed which greatly enhanced some areas of the approved centre. There were six teams with admitting rights to the approved centre collectively serving a population of over 100,000 people. A home based treatment team was available within the wider service.

There was one condition to registration: that the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group and provide a progress update to the Mental Health Commission on the programme of maintenance.

There was a very significant improvement in compliance with regulations, rules and codes of practice, from a very low level of 47% in 2017 to 79% in 2018. There were 11 compliances with regulations that were rated excellent. This reflected considerable input from staff and management into regulatory compliance and quality improvement and is to be commended.

Safety in the approved centre

Phase one of an anti-ligature window replacement project had been completed, but ligature anchor points still remained. Hazards, including large open spaces, slippery floors, hard and sharp edges, were not minimised in the approved centre. The angle of the showerhead and the size of the shower tray in the high dependency unit bathroom was a safety risk.
Regular food audits were carried out and kitchen areas and food storage areas were clean. Medication ordering, prescription, storage and administration were satisfactory. Not all staff were trained in the mandatory areas fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act. The approved centre completed risk assessments for all residents.

Appropriate care and treatment of residents

The processes for admission transfer and discharge were in accordance with the relevant code of practice. Each resident had an individual care plans but six of ten individual care plans inspected had not been developed, regularly reviewed and updated with input from the full multi-disciplinary team.
A range of therapeutic programmes was available to residents. The occupational therapist and occupational therapy assistant facilitated groups. There was rolling input into the therapeutic activity programme from psychology, social work, addiction counsellor, peer support worker, Regari Recovery College and Shine; this was coordinated by the occupational therapy department.

Registered medical practitioners assessed residents' physical health on admission, and as required. At a minimum, a six-monthly health assessment had been completed. For one resident on antipsychotic medication, the physical assessment did not include fasting glucose or prolactin levels. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required.

Respect for residents' privacy, dignity and autonomy

All residents wore their own clothing and had access to their personal property. They were free to communicate externally and there was a visiting area where visitors could be met in private. Single bedrooms could not be locked from the inside. Where residents shared rooms that were dormitory style, bed screening was inadequate as it did not provide full screening which compromised the residents' privacy. The night sitting room was overlooked by private housing. There were curtains in the night sitting room but it was possible to see in if the curtains were not drawn. The new sensory garden was overlooked by some bedrooms in the general hospital and the garden's glass wall contained sections of clear glass.

Appropriate signage and sensory aids had been improved from the previous inspection, however residents reported that there was confusion as to which were male and female showers.
In both seclusion and physical restraint, patients were not given adequate information about the reasons for or the duration of physical restraint or seclusion. There was compliance with Part of the Mental Health Act 2001 with regard to Consent to Treatment.

Responsiveness to residents' needs

A new fortnightly menu cycle had been introduced, a resident food satisfaction survey was being piloted, and a daily resident food satisfaction log was being maintained. A sensory garden had opened for residents since the last inspection. It was available throughout the day and early evenings. The relaxation room had been refurbished with guidance and input from the residents. A Peer Support Worker had commenced with the Rehabilitation and Recovery team and provided input into various committees and worked directly with service users in the approved centre. They provided recreational activities for residents. Information was provided to residents about the approved centre, their diagnosis and medication and side-effects. A complaints procedure was in place.
The approved centre was observed to be spotlessly clean. There had been recent upgrading to include the installation of new windows, beds, wardrobes and lockers. Five older style beds remained. The servery kitchen had been replaced and the relaxation room had been refurbished. The approved centre was not kept in a good state of repair internally and a number of areas of wear and tear were noted.

Governance of the approved centre

The approved centre was under the governance of Community Healthcare West (formerly CHO 2), which included counties Mayo, Galway and Roscommon. There were two area management teams and one was for the collective Galway and Roscommon Mental Health Services. There was also an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the Galway/ Roscommon Mental Health Service.

The approved centre held a monthly business meeting, and membership included the business manager, quality and risk advisor and a wide representation from all clinical personnel. The agenda included items that had various sub committees reporting to this forum for example Drugs and Therapeutic, Health and Fitness, and the Policy and Procedure Groups. The approved centre had a written policy in relation to risk management and incident management procedures, which met the requirements of the regulation. However, a number of key areas such as the process for investigating incidents, the process for reviewing and monitoring incidents and the roles and responsibilities for key staff responding to specific emergencies were missing from the policy.

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. The person with responsibility for risk was known by all staff in the approved centre. Incidents in the approved centre were recorded and risk-rated.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A new fortnightly menu cycle had been introduced, a resident food satisfaction survey was being piloted, and a daily resident food satisfaction log was being maintained. The kitchenette in the approved centre had been refurbished since the last inspection. A nutrition group had formed since the previous inspection.

2. A sensory garden had opened for residents since the last inspection. It was available throughout the day and early evenings.

3. A new individual care plan template in the form of a booklet had been introduced and was being piloted in the approved centre. The patient information booklet had been updated.

4. Visitors were now requested to sign a visitor's book on arrival to the approved centre.

5. Under the management of the Occupational Therapy Department, a Peer Support Worker had commenced with the Rehabilitation and Recovery team. They provided input into various committees and worked directly with service users in the approved centre.

6. A Health and Fitness committee had been established and met monthly. Initiatives commenced from this committee included the adaption of approved centre menu, walking and exercise groups, the introduction of recreational/activity boxes, and a smoking cessation programme.

7. Phase one of an anti-ligature window replacement project had been completed. Wardrobes and bedside lockers had all been replaced. All but five beds had been replaced. Each resident also had an individual locker in the property room.

8. An audit committee was established and included membership from the wider multi-disciplinary team.

9. An incident review committee was established that met at least fortnightly.

10. The relaxation room had been refurbished with guidance and input from the residents.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located on the ground floor of Roscommon University Hospital. It was registered for 22 beds, however, on the first day of the inspection an extra resident had been accommodated in a leave bed. This had occurred on three other occasions in 2018.

The approved centre was a long space occupying the rear of the hospital. It was divided by a conservatory area, which was at the main entrance. One section comprised of dining and day facilities to include consultant/allied health professional rooms; the other section included all of the bedrooms, nursing offices, and a night sitting room. There were three single rooms, two of which were located in a high dependency unit. All remaining sleeping accommodation was dormitory style. A sensory garden had opened since the previous inspection and was available to residents throughout the day and early evening. Phase one of a refurbishment plan had been completed which greatly enhanced some areas of the approved centre. Outstanding remediation works were evident.

There were six teams with admitting rights to the approved centre. They comprised of all Roscommon and the Ballinasloe, Portumna, Mountbellew, Glenamaddy, and Athlone regions of Galway, collectively serving a population of over 100,000 people. There were four general adult teams/sectors, a rehabilitation and recovery team, and a psychiatry of later life team. The psychiatry of later life team also served individuals from the Tuam region. A home based treatment team was available within the wider service.

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

Resident Profile	
Number of registered beds	***22***
Total number of residents	**23**
Number of detained patients	2
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	2
Number of patients on Section 26 leave for more than 2 weeks	2

4.2 Conditions to registration

There was one condition attached to the registration of this approved centre with effect from 1 March 2017.

Condition: To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance 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 under the governance of Community Healthcare West (formerly CHO 2), which encompassed counties Mayo, Galway, and Roscommon. There were two area management teams and one was for the collective Galway and Roscommon Mental Health Services. Meetings were held monthly and included representation from selected administrative and clinical personnel. The approved centre was represented by various heads of discipline. There was also an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Safety Meeting held monthly for the Galway/Roscommon Mental Health Service.

The approved centre held a monthly business meeting, which in turn reported into the committees outlined above, as applicable. Membership included the business manager, quality and risk advisor, and a wide representation from all clinical personnel. The agenda included items that had various sub committees reporting to this forum, for example the Drugs and Therapeutic, Health and Fitness, and Policy and Procedure groups.

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

- Clinical Director for Approved Centre
- Area Director of Nursing
- Occupational Therapy Manager

For nursing, occupational therapy, and medical staff it was evident that there were clear reporting and escalation structures. Responsibilities were clearly defined and the heads of discipline, who met the inspector, if not based in the approved centre, visited at least monthly but generally more often. They had been trained in risk management, incident reporting, and health and safety.

Recruitment and retention was ongoing and at times a difficulty for medical personnel. There was a registered medical practitioner and a 0.5 whole time equivalent occupational therapist in the approved centre Monday to Friday with a commitment to increase the occupational therapist position to one whole time equivalent. The position of a peer support worker on the rehabilitation and recovery team was acknowledged by all the heads of department interviewed as very positive and beneficial to service. Furthermore, there were links and involvement with the Recovery College REGARI (Roscommon, East Galway Recovery College), with peer educators from the college attending the approved centre fortnightly to introduce the residents to the college.

The inspection team also met with the area lead for mental health engagement who had responsibility for the establishment of local forums for service users, family members, carers, and supporters. The area lead

for mental health engagement sat on the area management team and raised local and wider service issues as appropriate.

4.5 Use of restrictive practices

The main entrance to the approved centre was locked throughout the inspection. There was a log of the times that these doors were locked and it was apparent that this was the normal practice. On occasion, the doors were open but staff reported this was very infrequent.

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	✓		✗	Moderate	✗	Moderate
Regulation 19: General Health	✓		✗	High	✗	Low
Regulation 21: Privacy	✗	High	✗	High	✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	High
Rules Governing the Use of Seclusion	✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Moderate	✗	Moderate	✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 29: Operating Policies and Procedures
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 had not admitted any children since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were 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.
- The Irish Advocacy Network (IAN) representative 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.

The inspection team met with four residents. Residents were generally complimentary about the service and in particular, the activities provided. It was reported that residents knew their respective multi-disciplinary team and keyworker. The approved centre was described by residents as spotless, however it was suggested by a resident that there was not enough showers and toilets. While there were identified facilities for visiting, the residents indicated that they would prefer a dedicated visiting room. Residents also reported confusion between the male and female showers.

Three residents completed resident questionnaires were returned to the inspectors. Two indicated that the residents understood their care plan, and two of three indicated they knew who their key worker was. Two of three indicated that they had space for privacy however only one felt their privacy and dignity were respected. On a scale of 1-10, with 1 being poor and 10 being excellent, one resident rated 10 out of 10 for overall experience of care and treatment, one resident rated 7, and one resident rated 2.

The Irish Advocacy Network (IAN) visited the approved centre weekly. There was a notice naming the IAN contact and details. The inspector met with the IAN representative to discuss issues and positive aspects as reported by residents. It was reported that staff were friendly, helpful, and supportive; that there was a very good activities programme; and overall the food was good. Areas for improvement suggested by residents to the advocate included allied health professional staff not being replaced while on extended leave and a lack of privacy in for those residents accommodated in the dormitories directly beside the nursing station.

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:

- Executive Clinical Director (Acting)
- Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Consultant Psychiatrist
- Clinical Nurse Manager 111 X 2
- Assistant Director of Nursing
- Registered Proprietor
- Area Lead for Mental Health Engagement
- Catering X 2
- Clinical Nurse Manager 11 X 2
- Business Manager
- Mental Health Act Administrator
- Non Consultant Hospital Doctor
- Regional Nurse Practice Development Coordinator

Apologies were received on behalf of the general 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 November 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 identifying residents, as set out in the policy.

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

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs, were used. Identifiers were person-specific and appropriate to the residents' communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare, therapeutic services, and programmes. There was an alert system for identifying 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 June 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: A systematic review of menu plans had been undertaken by Roscommon University Hospital Nutrition and Hydration Committee, with input from the mental health dietitian, 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. A food satisfaction survey had been piloted and a daily resident food satisfaction log had been maintained following the introduction of a new menu cycle.

Evidence of Implementation: Food was prepared in the general hospital kitchen and menus were approved by the general hospital's dietitian and the Nutrition and Hydration Committee, with input from the approved centre's mental health dietitian. The approved centre had introduced a new fortnightly menu cycle on a pilot basis six weeks prior to the inspection.

Residents were provided with a variety of wholesome and nutritious food. There were at least two choices for meals and food, including modified consistency diets. Meals were attractive and appealing in presentation. Hot and cold drinks were offered regularly to residents and a source of safe, fresh drinking water was available at all times. Hot meals were provided on a daily basis.

An evidence-based nutrition assessment tool was used. Where appropriate, weight charts were implemented, monitored and acted upon. Residents, their representatives, family, and next of kin were educated about residents' diets, where appropriate. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Nutritional and dietary needs were addressed in the residents' individual care plans.

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 November 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Food preparation, handling, storage, distribution, and disposal controls.
- The management of catering and food safety equipment.

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

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in the main kitchen of the general hospital and was transported to the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to residents' clothing, which were last reviewed in March 2018. The policies combined 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 residents' clothing, as set out in the policies.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No resident was prescribed nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents' clothing was clean and appropriate to their needs. Emergency clothing was available if it was required. Residents changed out of nightclothes during the day unless otherwise specified in their individual care plans, and all 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 October 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process to allow a resident access to, and control over, their personal property and possessions, unless this poses a danger to the resident, or others, as indicated by a risk assessment and the resident's individual care plan.

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

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

Evidence of Implementation: Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of monies, valuables, and personal effects. Residents also had access to individual lockers with locks.

On admission, the approved centre compiled a detailed property checklist. These were filed separately from the resident's individual care plan and were available to residents. Residents were supported to manage their own property, unless it posed a danger to the resident or others, as indicated in their individual care plan.

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 uptake and 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. Recreational activities included arts and crafts, a walking group, table tennis, and music. There were televisions, DVDs, books, board games, and newspapers available to the residents. Activity boxes were available in the main ward area and in the high dependency unit. A peer support worker was available to residents on the rehabilitation and recovery team and facilitated recreational activities as practicable. A sensory garden had opened in the approved centre since the last inspection.

The recreational activity programme had been developed, implemented and maintained for residents with resident involvement. Where appropriate, individual risk assessments had been completed in relation to the selection of appropriate activities. The recreational activities were appropriately resourced and there were opportunities for indoor and outdoor exercise and physical activity. Documented records of attendance had been retained in group records and within the residents' clinical files.

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, which was last reviewed in November 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 were facilitated to practice their religion insofar as was practicable. Mass was celebrated in the general hospital most Sundays. Residents had access to multi-faith chaplains.

The care and services provided in the approved centre were respectful of the residents' religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. 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 and procedures in relation to visits, which was last reviewed in June 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: 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. Visiting areas were provided, including private visiting rooms. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visitors were requested to sign a book on arrival to the approved centre. Children visiting were accompanied at all times and this had been communicated to all relevant individuals. The sitting room and visiting areas 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 **Excellent**

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had been completed to identify ways of improving communication processes.

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

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

Regulation 13: Searches

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 and procedures in relation to the implementation of resident searches, which was last reviewed in October 2015. The policy and procedures 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 policy 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 had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: The clinical file of a resident who had been searched was reviewed. Risk had been assessed prior to the search and resident consent had been sought. This was documented. The resident search policy and procedures had been communicated to all residents. The resident had been informed by those implementing the search of what was happening during a search and why. A minimum

of two clinical staff were in attendance during the search which had been implemented with due regard to the resident's dignity, privacy and gender.

A written record of every search of a resident and every property search was available and 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 pillar.

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 a written operational policy and protocols in relation to care of the dying, which was last reviewed in March 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

As no resident had died or had required end of life care since the last inspection, the monitoring and evidence of implementation pillars were not inspected against.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

Evidence of Implementation: Ten ICPs were reviewed by the inspector. There was evidence which showed that each of these residents had an initial admission assessment and an initial care plan had been drawn up to address the immediate needs of the resident.

Thereafter six of the ten ICPs inspected had not been developed or reviewed with input from the full MDT. There was no evidence of psychology or social work input into these six care plans. All ten ICPs had been developed within seven days of admission and identified appropriate needs, goals, and interventions. One ICP did not identify the resources required to provide the care and treatment identified.

Comprehensive assessments had been completed that included medical, psychiatric and psychosocial history, medication history and current medication, current physical health assessment, and a detailed risk assessment. The assessments also included communication abilities, social, interpersonal, and physical environment-related issues, including resilience and strengths. All ICPs had been updated following weekly review and residents had been offered a copy. Each ICP had been signed by the resident. A primary nurse had been identified daily as the keyworker.

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

a) **Six of ten ICPs inspected had not been developed, regularly reviewed and updated with input from the full multi-disciplinary team.**
b) **One ICP reviewed did not identify the resources required to provide the care and treatment required.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of 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 directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident. A range of therapeutic programmes was available to residents. The occupational therapist and occupational therapy assistant facilitated cooking skills, recovery, relaxation, mindfulness, healthy lifestyle, and physical exercise groups. There was rolling input into the therapeutic activity programme from psychology, social work, addiction counsellor, peer support worker, Regari Recovery College, and Shine; a national organization dedicated to upholding the rights and addressing the needs of all those affected by mental ill health. This had been coordinated by the occupational therapy department. A daily and weekly schedule was available to the residents.

Residents had access to occupational therapy, social work and clinical psychology on an individual basis as required. One team did not have a psychologist or social work but there was evidence that cross care cover was provided if required. The clinical files showed evidence of the provision of dietetics and physiotherapy as required.

Therapeutic services and programmes were provided in separate dedicated rooms and records had been maintained of participation, engagement, and outcomes achieved, within the resident's individual care plan or clinical file.

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 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

(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: 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 was inspected. Communication records with the receiving facility were documented and included the reason for transfer and the resident's care and treatment plan. An assessment of the resident was completed prior to transfer, including a risk assessment relating to the transfer and the resident's needs.

A letter of referral, including a list of current medications, a transfer form, and a list of required medication for the resident during the transfer process was issued with copies retained as part of the transfer documentation. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility. All records relevant to the transfer were retained in the resident's clinical file.

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 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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 a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in August 2018. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

Training and Education: 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 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 recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access to an Automated External Defibrillator, which had been checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents' physical health on admission, and general health needs were managed thereafter. At a minimum, a six-monthly health assessment had been completed. For one resident on antipsychotic medication, the physical assessment did not include fasting glucose or prolactin levels. Dental health had not been documented as checked in the six-monthly health assessment.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services, as required. National screening programme information was available, and residents could access national screening programmes, as applicable to resident needs.

There was a policy on tobacco use and how smoking cessation was implemented. Nicotine replacement therapy was available and residents were supported to stop smoking.

The approved centre was non-compliant with this regulation because the six-monthly general health needs assessment was incomplete for one resident, 19(1) (b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the 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: An information booklet was provided to residents and their representatives on admission. An updated information booklet was distributed to residents during the inspection. This contained details of the housekeeping arrangements such as mealtimes, the complaints procedure, visiting times and arrangements, the arrangements for personal property, and details of the relevant advocate and voluntary agencies. The handbook addressed residents' rights. Residents and their families were provided with information on their multi-disciplinary team.

Residents and their families received written and verbal information regarding diagnosis and the likely adverse effects of treatment. Medication information sheets as well as verbal information were provided, and these included information on indications for use and possible side effects of medication. The information provided by the approved centre was evidence-based but had not always been appropriately reviewed. It was at times printed from the Internet. As required, residents had access to interpretation and translation services.

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the 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: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Residents wore clothing that respected their privacy and dignity. Staff were observed to use discretion when discussing the resident's condition or treatment needs.

The approved centre's layout and furnishings were not always conducive to resident privacy and dignity. All bathrooms, showers, and toilets had locks on the inside of the doors and the locks had an override facility. Single bedrooms could not be locked from the inside. Where residents shared rooms that were dormitory style, bed screening was inadequate as it did not provide full screening which compromised the residents' privacy. The night sitting room was overlooked by private housing. There were curtains in the night sitting room but this window glass was clear and not opaque. The new sensory garden was overlooked by some bedrooms in the general hospital and the garden's glass wall contained sections of clear glass.

The noticeboard displaying resident names and identifiable information had a folding mechanism and was kept obscured from general view.

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

a) **Bed screening was not always in place.**
b) **The night sitting room was overlooked by private housing.**
c) **The sensory garden was overlooked by the general hospital.**

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 May 2018.

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

Monitoring: The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space that included appropriately sized communal rooms, and to shared space in the form of well-lit and comfortably heated and ventilated communal rooms. There was sufficient space for residents to move about, including an outdoor sensory garden. This had been an addition since the previous inspection.

Appropriate signage and sensory aids had been improved from the previous inspection, however residents reported that there was confusion with the male and female showers. Hazards, including large open spaces, slippery floors, hard and sharp edges, were not minimised in the approved centre. The angle of the shower head and the size of the shower tray in the high dependency unit bathroom was a risk. There had been recent ligature works with the completion of the first phase of window replacement. Ligature points were not minimised to the lowest practicable levels.

The approved centre was not kept in a good state of repair internally. There was no programme of routine maintenance and renewal of the fabric and decoration of the premises. A number of areas of wear and tear were noted in the approved centre. Curtain hooks were broken on one dormitory bedroom window,

two bedroom walls were painted half way up the wall, and an observation panel and internal doors in the high dependency unit had been broken since December 2017.

There had been recent upgrading to include the installation of new windows, beds, wardrobes, and lockers. Five older style beds remained. The servery kitchen had been replaced and the relaxation room had been refurbished.

There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. A cleaning schedule was implemented and the approved centre was observed to be spotlessly clean. Rooms were centrally heated but the temperature could not be controlled from the residents own room. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. It was noted that the toilet nearest to the dining room was not in use. Wheelchair accessible toilet facilities were identified for use by residents and visitors who required such facilities. The approved centre had a designated sluice room although it was also used for storage at the time of the inspection, a designated cleaning room, and a laundry room. The approved centre provided assisted devices and equipment as required to address residents' needs.

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

a) **Curtain hooks were broken on one window, two bedroom walls were half painted and an observation panel and internal doors in the high dependency unit had not been repaired; therefore, the approved centre had not been maintained in good structural and decorative condition 22(1) (a).**
b) **The shower head and shower tray in the high dependency unit were a hazard, therefore, the physical structure had not been properly maintained with due regard to the specific needs of the resident's 22(3).**
c) **Ligature points were not minimised to the lowest practicable levels, therefore the approved centre had not been maintained with due regard to the safety of residents 22(3).**

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in June 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: All nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing and medical staff as well as pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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: The MPARs for ten of the residents were inspected. A record of allergies or sensitivities to any medications, including if the resident had no allergies, was documented for all. The generic names of medications and preparations were written in full with dedicated spaces for routine medications, once-off medications, and “as required” medications. The frequency of administration, the dosage, and the administration route for medications were recorded. Micrograms had not been written in full and had been abbreviated. There was a record of all medications administered to the residents, which included any medications refused by residents. There was a clear record of the date of initiation and discontinuation, where applicable, for each medication, along with the signature and Medical Council Registration Number of the medical practitioner.

All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner and appropriately dispensed. The expiry dates of medications were checked prior to their administration, and good hand hygiene and cross infection control techniques were implemented when medication was being dispensed.

Controlled drugs were checked by two staff members against the delivery form, and the details were appropriately entered in the controlled drug book. At the time of inspection, no residents were self-administering medications and no resident had been prescribed medication to be crushed.

Medication arriving from the pharmacy was verified against the order to ensure that it was correct and accompanied by appropriate directions for use. Medication was appropriately stored, and medication storage areas were clean and tidy. The clinical room was noted to be confined. Food was not stored in

areas used for the storage of medication. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit had been taken daily and recorded.

Medication was stored securely in a locked trolley within a locked room. There was a separate secure storage area for scheduled controlled drugs. A system of stock rotation was implemented, and an inventory of medications was completed monthly by nursing staff. Expiring medications were returned to the pharmacy.

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 evidence of implementation pillar.

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 a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in March 2018.It also had an associated safety statement, dated January 2018. The policy and safety statement addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The fire management plan.
- Infection control measures relating to the following:
  - Raising awareness of residents and their visitors to infection control measures.
  - Covering of cuts and abrasions.
  - Management and reporting of an infection outbreak.
  - Support provided to staff following exposure to infectious diseases.
  - Specific infection control measures in relation to infection types, e.g. C. diff, MRSA, Norovirus.
- Falls prevention initiatives.
- Vehicle controls.

Training and Education: 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 policy.

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

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

The approved centre was compliant with this regulation.

Regulation 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 April 2018. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. 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 that identified the leadership and management structure, lines of authority, and accountability of the approved centre's staff. There was a planned and actual staff rota. The numbers and skill mix of staffing were sufficient to meet resident needs. There had been agreement with senior management to increase the occupational therapy input from 0.5 Whole Time Equivalent to a full time position.

Staff had been recruited and selected in accordance with the approved centre's policy and procedure, which was managed through the HSE National Recruitment Service. An appropriately qualified staff member was on duty and in charge at all times. There was no written staffing plan but there were clearly defined processes to manage skill mix, competencies, number, and qualification of staff. The approved centre utilised agency staff and there was a comprehensive contract that set out the agency's responsibilities, and included the vetting of staff.

An annual staff training plan had been completed that identified required training and skills development in line with the assessed needs of the resident group profile. Not all healthcare professionals were up-to-date with Children First, Basic Life Support (BLS), fire safety, Mental Health Act 2001 training, and Therapeutic Management of Aggression and Violence (TMAV) or Management of Actual or Potential Aggression (MAPA). This was being actively managed and improvements were evident since the last inspection, although no training details were furnished to the inspector from the social work or psychology department.

Other training completed included manual handling, risk management, recovery-centred approaches, and care for residents with intellectual disability. All staff training had been documented and staff training logs were maintained. Opportunities had been made available to staff for further education and in-service training had been completed by appropriately trained individuals.

The Mental Health Act 2001, the associated regulations and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM 3	1	1 (Acting)
	CNM 2	1	
	RPN	5	4
	HCA	1	1
	Occupational Therapist	0.5 WTE	
	Occupational Therapy Assistant	1	

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

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

a) **Not all healthcare professionals had up-to-date mandatory training in fire safety, Children First, BLS, and TMAV or MAPA, 26(4).**
b) **Not all healthcare professionals had completed mandatory Mental Health Act 2001 training, 26(5).**

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records, which was last reviewed in March 2018. The policy and procedures addressed all of the requirements the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents' records.
- Record retention periods.
- The destruction of records.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Residents' records were secure, up to date, in good order, and constructed, maintained, and used in line with national guidelines and legislative requirements. The records were appropriately secured and where possible, were physically stored together.

A record had been initiated for every resident in the approved centre, and these were reflective of residents' current status and the care and treatment being provided. Resident records were maintained through the use of an identifier that was unique to the resident, along with the resident name, address, and date of birth. Resident records were developed and maintained in a logical sequence and they were accessible to authorised staff only.

Records were written legibly and contained factual, consistent, and accurate entries. Each entry noted the time using the 24-hour clock and was followed by a signature. It was noted that where an error had been

made, it had been scribbled out so that it was illegible, as opposed to scored out with a single line and the correction alongside.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of 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 training and education and evidence of implementation pillars.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in June 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The operating policies and procedures of the approved centre had been developed with input from clinical and managerial staff and in consultation with all relevant stakeholders as appropriate. The Clinical Policy Procedure Protocol Group, which encompassed the Galway/Roscommon Mental Health Services had met monthly up to the end of 2017 and had then reverted to every second month. There were four audit committee representatives from approved centre on this group.

The policies had been appropriately approved and had been communicated to all relevant staff. Policies that were required by regulation to be reviewed within three years were compliant. Obsolete versions were retained but had been removed from possible access by staff. The format was standardised. No generic policies had been used but had been appropriately referenced in applicable policies.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **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 March 2017. The policy and procedures 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 had provided private facilities specifically to support the Mental Health Tribunal Process. Staff assisted and supported patients to attend and participate in the process, where necessary.

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 policy in relation to the management of complaints, which was last reviewed in October 2015. It also used the HSE's *Your Service, Your Say* procedure, which was last reviewed in November 2017. The policies and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed. Therefore, required actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated individual with responsibility for dealing with all complaints, who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy and the resident information booklet. The approved centre's management of the complaints processes was well publicised and accessible to residents and their representatives. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All complaints were documented and dealt with by the local nominated complaints officer.

The inspection was informed that no complaints had been made to the nominated complaints officer for the wider service through the *Your Service Your Say* process since the last inspection. Details of complaints and of subsequent investigations and outcomes were fully recorded and kept distinct from residents' individual care plans.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

The policy did not address the following:

- The responsibilities of the Multi-Disciplinary Team.
- The process of identification for organisational risks.
- The process of identification for risks to the resident group during the provision of general care and services.
- The process for investigating incidents.
- The process for reviewing and monitoring incidents.
- The roles and responsibilities for key staff responding to specific emergencies.
- The process for communication responding to specific emergencies.

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. Not all staff had been trained in incident reporting and documentation. 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. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The risk management policy had been implemented throughout the approved centre. Responsibilities were allocated at management level to ensure the effective implementation of risk management. The person with responsibility for risk was known by all staff in the approved centre. Risk management procedures actively sought to reduce identified risks. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register. Structural risks including ligature points were evident. Remediation works were partially completed and associated risk was managed with individual risk assessment, individual care planning and staffing.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, and in conjunction with medication requirements or administration. The multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Incidents in the approved centre were recorded and risk-rated using an Incident and Near Miss Report form, and then inputted into the National Incident Management System. Serious incidents were recorded using the HSE Safety Incident Management Communication/Escalation Form. There was a local incident review committee that met at least fortnightly. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the local policy and the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. The approved centre had an emergency plan that incorporated fire evacuation procedures. This was under review at the time of the inspection.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently directly inside the main entrance of the approved centre.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated February 2018. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

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

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

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion facility was furnished and maintained to ensure respect for resident dignity and privacy. Furniture and fittings were designed so as not to endanger patient safety. There was no CCTV and residents in seclusion were directly observed by nursing staff through a window.

Seclusion was initiated by a registered medical practitioner and/or a registered nurse. The consultant psychiatrist was notified as soon as was practicable. Seclusion occurred after an assessment, which included a risk assessment, and this was recorded in the clinical file and seclusion register by the person who had initiated it. The registered medical practitioner indicated the duration of the order, which was for a period in the first instance of no longer than eight hours. A medical review was undertaken no longer than four hours after the commencement of each episode of seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

Three episodes of seclusion were reviewed by the inspector. In each episode, seclusion had been used in rare and exceptional circumstances and in the resident's best interests. Cultural awareness and gender sensitivity had been demonstrated. In two cases there was no documented evidence that the resident had been informed of the reasons for, likely duration of, and circumstances leading to discontinuation of seclusion.

Residents were directly observed by a registered nurse for the duration of the seclusion episode and a written record of the resident was made every 15 minutes. A nursing review was undertaken every two hours and when applicable a medical review had been undertaken every four hours. The residents had been informed of the ending of the episode of seclusion and the reason for ending seclusion had been recorded in the respective clinical files. All uses of seclusion inspected had been clearly recorded on the seclusion register. A copy of the seclusion register had been placed in the clinical file. In one episode, there was no documented evidence that there had been a review of the seclusion episode by members of the multi-disciplinary team within two working days after the episode of seclusion.

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

a) **In two episodes of seclusion there was no documented evidence that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of seclusion, 3.6.**
b) **In one episode of seclusion there was no documented evidence that there had been a review by members of the multi-disciplinary team within two working days after the episode of seclusion, 10.3.**

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. The patient had consented to receiving treatment. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment. The written record of consent recorded the following:

- The name of the medications prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient which had taken place on the nature and purpose of the medications, the effects of the medications, including the risks and benefits and any views expressed by the patient, and any supports provided to the patient in making the decision to consent.

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

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated March 2018. It addressed the following:

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

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

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed. The approved centre had a physical restraint risk assessment form and physical restraint check list and audit tool.

Evidence of Implementation: Clinical files relating to three episodes of physical restraint were inspected. Physical restraint had been used in rare, exceptional circumstances and in the best interests of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated. There was no evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

Physical restraint had been initiated by a registered medical practitioner, registered nurse, or other member of the multi-disciplinary team. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed for each episode of physical restraint. In one episode, there was no documented evidence or indication that the next of kin had been informed or not.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the residents' needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Residents were given the opportunity to discuss the episode with members of the multi-disciplinary team as soon as was practicable. Completed clinical practice forms had been placed in the resident's clinical file.

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

a) **In the three episodes reviewed there was no documented evidence that the resident was informed of the reasons for, likely duration of and circumstances leading to discontinuation of physical restraint, 5.8.**

b) For one episode there was no documented evidence, that with the resident's consent or where the resident was unable to consent, that the next of kin had been informed of the resident's restraint, 5.9(a).

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in November 2016, addressed all the policy-related criteria for this code of practice. These included a procedure for involuntary admission and protocols for urgent referrals, self-presenting individuals, planned admissions, and timely communication with general practitioners/primary care and community mental health teams.

Transfer: The transfer policy, which was last reviewed in June 2017, addressed all the policy-related criteria for this code of practice. These included the procedure for involuntary transfer and the roles and responsibilities of staff in relation to the transfer of residents.

Discharge: The discharge policy, which was last reviewed in March 2018, addressed all the policy-related criteria for this code of practice. These included procedures for the discharge of involuntary patients and managing discharge against medical advice. There were protocols for discharging homeless people and older persons.

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

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

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

Admission: One clinical file was inspected in relation to admission. The approved centre had a key worker system in place by way of a primary nurse. The decision to admit was made by the registered medical practitioner or consultant psychiatrist. The resident was assessed at admission, and details of all assessments were documented in the clinical file. This included a risk assessment and full physical examination.

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

Discharge: One clinical file was examined in relation to discharge. The resident's individual care plan contained a discharge plan and documented communication with the relevant primary care team. A discharge meeting had been convened and attended by relevant persons. The resident was comprehensively assessed prior to discharge. The community mental health team/primary care team was informed of the discharge, and a comprehensive discharge summary was issued within 14 days.

The approved centre was compliant with this code of practice.

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

Regulation 15: Individual Care Plan

Report reference: Page 31

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. Six of ten ICPs inspected had not been developed, regularly reviewed and updated with input from the full multi-disciplinary team.	*Reoccurring*	Corrective Action(s): Ensure each care plan demonstrates evidence of full MDT input by alerting verbally and by email all treating teams of this need and follow this up with further audit. Since the inspection two allied health professionals have been appointed to the two teams with vacancies this will also assist compliance Post-Holder(s) responsible: Treating Consultants, Clinical director, Registered proprietor and allied health professionals line managers	Quarterly MDT Care plan audits	This is achievable however, one team is still lacking a social worker. Filling of this post is being actively pursued And the inpatient unit is still awaiting a fulltime Occupational therapist.	4 Months
		Preventative Action(s): 1) Ensure all multidisciplinary teams are fully resourced	1)Team templates to be reviewed 6 monthly to establish if vacancies exist and ensure same highlighted to Area management and that	Achievable	6 months

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

		2)Feedback of informal and formal audit results 3) Continue to provide training to teams on the Individual Care planning technique. Post-Holder(s) responsible: Mental Health Act Coordinator ,CNM3,Clinical Director, Registered Proprietor	arrangements are in place to ensure all inpatients have full MDT Input into their care 2) Results of quarterly ICP audit will be presented to all teams in the unit and recommendations made as necessary 2) Log of training will be kept		
2. One ICP reviewed did not identify the resources required to provide the care and treatment required	*Reoccurring*	Corrective Action(s): Ensure all current care plans have the resource/s identified to fulfil all actions in their care plan Post-Holder(s) responsible: Treating Consultants, Mental Health Act administrator, Clinical Director,CNM3	Quarterly Individual Care Plan audits	Achievable	3 months
		Preventative Action(s): Keyworker to review ICP's weekly to monitor for any omissions Quarterly audit with timely feedback Post-Holder(s) responsible: Team Keyworkers, Mental Health Act Administrator ,CNM3	Quarterly Audit	Achievable	3 months

Regulation 19: General Health

Report reference: Page 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)*
3. The six-monthly general health needs assessment was incomplete for one resident, 19(1) (b).	*Reoccurring*	Corrective Action(s):All old physical health check forms removed from approved unit only new updated forms are available these are used to ensure full compliance 100% compliance on approved unit with this requirement currently Post-Holder(s) responsible: Treating consultant and NCHD ,CNM2, Mental health act administrator	6 monthly audit	Achievable	Closed
		Preventative Action(s): New checklist available to prompt all assessments required for compliance with this regulation 6 monthly Audit of Regulation 19 Post-Holder(s) responsible: Treating consultant ,C Director, Mental Health act administrator	6 monthly audit	Achievable	Ongoing

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)*
4. Bed screening was not always in place.	*Reoccurring*	Corrective Action(s): New Bed screening was on order at the time of inspection. These are now in place. This non compliance is corrected. Post-Holder(s) responsible:CNM3	New screening now visibly in place 6 monthly Audits re compliance with Regulation 21 : Privacy will take place	Achieved	Closed
		Preventative Action(s): Regular Inspection of unit by staff And regular audits of compliance with regulation 21 Post-Holder(s) responsible:CNM3	As above	Achievable	6 months
5. The night sitting room was overlooked by private housing	*New*	Corrective Action(s): A Privacy Audit has taken place on the approved unit, Windows requiring opaque Glass have been identified and this will be put in place within a matter of weeks Post-Holder(s) responsible: CNM3,ADON,Clinical Director	This will be followed up at our monthly business meeting and by repeat Audit of Regulation 21: Privacy	Achievable	2 months
		Preventative Action(s): Continue to conduct 6 monthly Privacy audits to ensure continued compliance Post-Holder(s) responsible: CNM3,ADON,Clinicl Director	6 monthly Audit Of Regulation 21 :Privacy	Achievable	6 months

6. The sensory garden was overlooked by the general hospital	*New*	Corrective Action(s): The areas overlooking the sensory garden have been identified Liasion is now actioned to take place with the general hospital with regard to correcting this matter Post-Holder(s) responsible: ADON,CNM3	Repeat audit of regulation 21 And regular inspection by staff	Agreement will have to be reached with the general hospital on measures to remedy this non compliance	6 months

Regulation 22: Premises

Report reference: Pages 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)*
7. Curtain hooks were broken on one window, two bedroom walls were half painted and an observation panel and internal doors in the high dependency unit had not been repaired; therefore, the approved centre had not been maintained in good structural and decorative condition 22(1) (a).	*Monitor as per condition*[3]				
8. The showerhead and shower tray in the high dependency unit were a hazard, therefore, the physical structure had not been properly maintained with due regard to the specific needs of the resident's 22(3).					
9. Ligature points were not minimised to the lowest practicable levels, therefore the approved centre had not been maintained with due regard to the safety of residents 22(3).					

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

Regulation 26: Staffing

Report reference: Page 43 & 44

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
10. Not all healthcare professionals had up-to-date mandatory training in fire safety, Children First, BLS and TMAV or MAPA, 26(4). 11. Not all healthcare professionals had completed mandatory Mental Health Act 2001 training, 26(5).	*Reoccurring*	Corrective Action(s): Staff who have not completed Mandatory training have been identified .The relevant line managers have been informed. Since the inspection mandatory training in the five identified areas(10 and 11) has been ongoing and more staff now have completed training in each of the five areas, this is being monitored and audited and there is ongoing updates and feedback on current deficits to relevant line managers and staff Post-Holder(s) responsible: CNM3, Practice development coordinator,ADON,C Director	Measurable through audit of training logs	Achieving full compliance for all staff is a challenge however this is a strong commitment to attaining same	6 months
		Preventative Action(s): Regular 3 monthly audit of Mandatory training logs Regular prompting of staff by relevant line managers Post-Holder(s) responsible:	As Above	Achievable	6 months

Section 69: The use of Seclusion

Report reference: Page 57 & 58

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
12. In two episodes of seclusion there was no documented evidence that the resident had been informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of seclusion, 3.6.	*Reoccurring*	Corrective Action(s): Ensure relevant Staff consult the seclusion checklist routinely throughout the period of seclusion and identify any omissions in particular those highlighted in area 12 here opposite and ensure they are attended to and documented in the required timeframe. Continue ongoing training and feedback on the rules/requirements governing Seclusion to all relevant Staff Post-Holder(s) responsible: CNM3	3 Monthly Audit	Achievable	6 months
		Preventative Action(s): Regular 3 monthly Audit Regular prompting of relevant staff re compliance /Feedback Ongoing training as above Post-Holder(s) responsible:	3 monthly Audit and feedback to relevant staff	Achievable	6 months

		CNM3			
13. In one episode of seclusion there was no documented evidence that there had been a review by members of the multi-disciplinary team within 2 working days after the episode of seclusion, 10.3.		Corrective Action(s): All episodes of seclusion to have documented evidence of MDT within 2 working days. Relevant staff to regularly consult the seclusion checklist during each episode of seclusion to ensure full compliance with MDT Review documentation Further training and prompting of relevant staff. Post-Holder(s) responsible: CNM2, CNM3, ADON, Consultant Psychiatrist, C. Director.	Audit all seclusion episodes Quarterly as per Code of Practice. Ensure post seclusion checklist is completed for each episode of seclusion and audit these quarterly.	Achievable	6 months
		Preventative Action(s): Ongoing training and audit quarterly. Post-Holder(s) responsible: CNM3, Practice Development Co-ordinator, Allied Health Professionals, Consultant Psychiatrists, C. Director.	Audit all seclusion episodes quarterly	Achievable	6 months

Code of Practices: Use of Physical Restraint

Report reference: Page 62 & 63

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
14. In the three episodes reviewed there was no documented evidence that the resident was informed of the reasons for, likely duration of and circumstances leading to discontinuation of physical restraint, 5.8.	*Reoccurring*	Corrective Action(s): Have documentary evidence for all episodes of physical restraint that the resident has been given all information required regarding the reasons for, likely duration and the circumstances leading to the discontinuation of the physical restraint Provide further training to relevant staff regarding physical restraint documentation. Provide feedback from audit to relevant staff regarding documentation requirements. Provision of physical restraint checklist as aide memory to assist compliance. Post-Holder(s) responsible: CNM3, Practice Development Co-ordinator.	Audit as per Code of Practice on a quarterly basis.	Achievable	6 months
		Preventative Action(s): Ongoing training and audit this code quarterly. Post-Holder(s) responsible: CNM3, Practive Development Co-ordinator, C. Director.	3 monthly Audit of Physical restraint practice	Achievable	6 months

15. For one episode there was no documented evidence, that with the resident's consent or where the resident was unable to consent, that the next of kin had been informed of the resident's restraint, 5.9(a).	*Reoccurring*	Corrective Action(s): Ensure all items on physical restraint check list are complied with and in the timelines recommened and in particular those outlined in noncompliance number 15 opposite Provide further training to relevant staff regarding physical restraint documentation. Provide feedback from audit to relevant staff regarding documentation requirements. Post-Holder(s) responsible: CNM2, CNM3, ADON, Practice Development Co-ordinator	Audit as per Code of Practice on a quarterly basis.	Achievable	6 months
		Preventative Action(s): Ongoing training and audit quarterly**.** Post-Holder(s) responsible: CNM3, Practice Development Co-ordinator			