Highfield Hospital

ID Number: AC0088

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Highfield Hospital
Swords Road
Whitehall
Dublin 9

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Forensic Mental Health Care
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
30 March 2018

Conditions Attached:
None

Registered Proprietor:
Mr Stephen Eustace

Registered Proprietor Nominee:
N/A

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
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Inspection Date:
17 – 20 April 2018

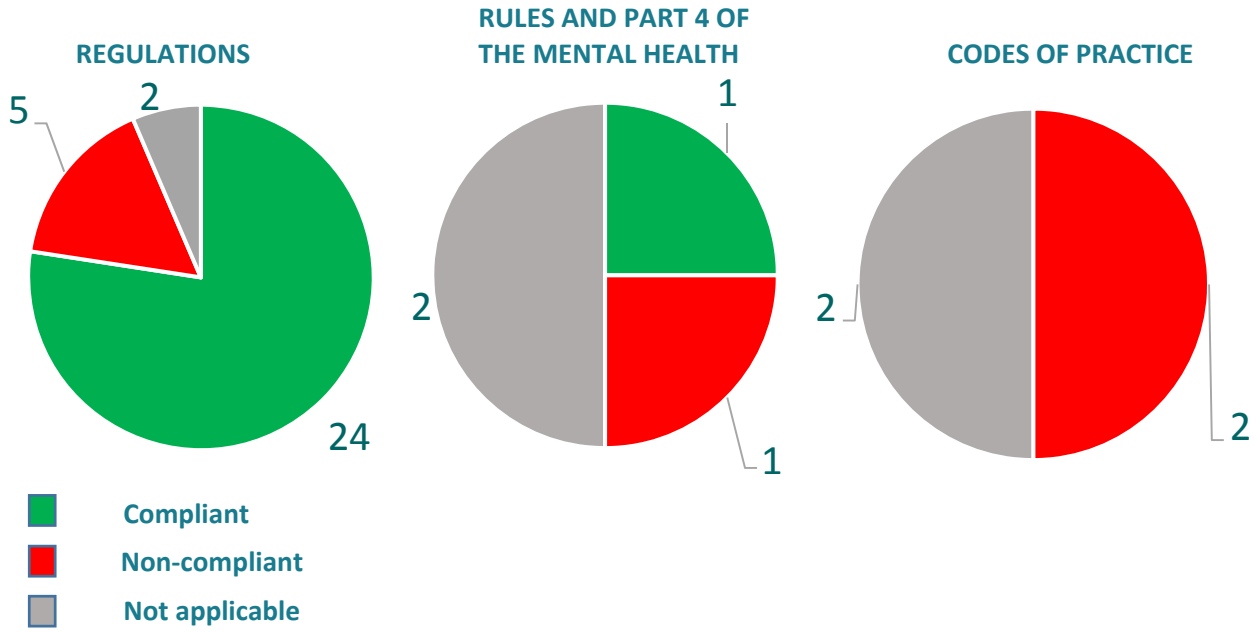
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
18 – 21 July 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
15 November 2018

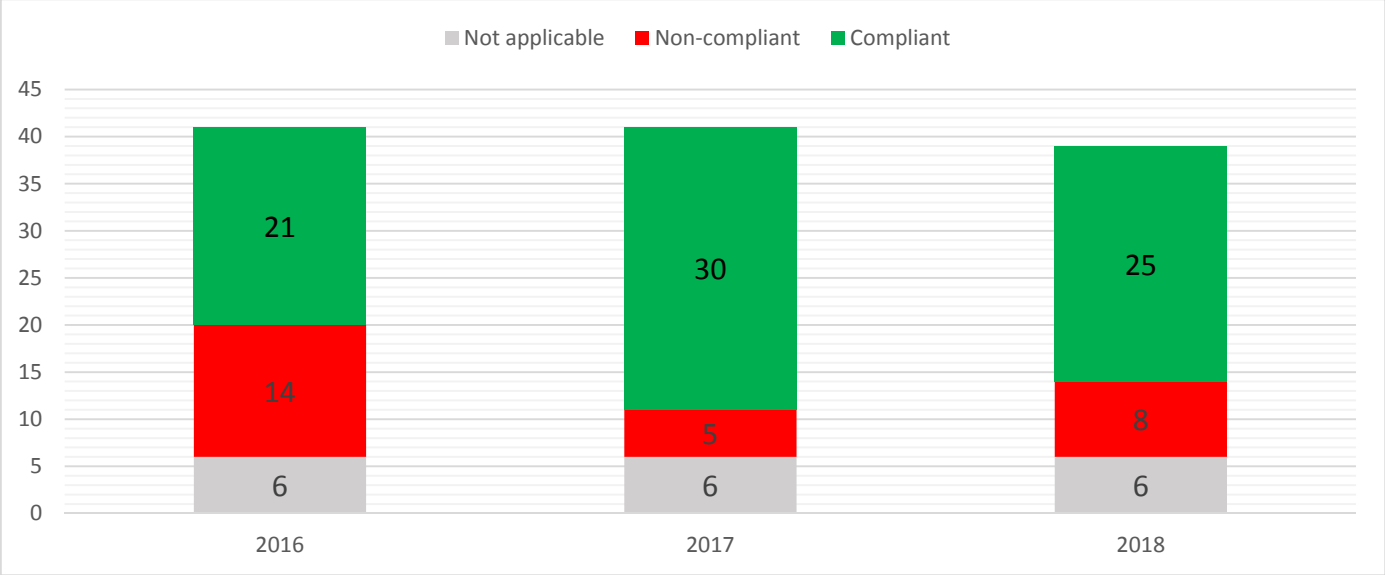
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

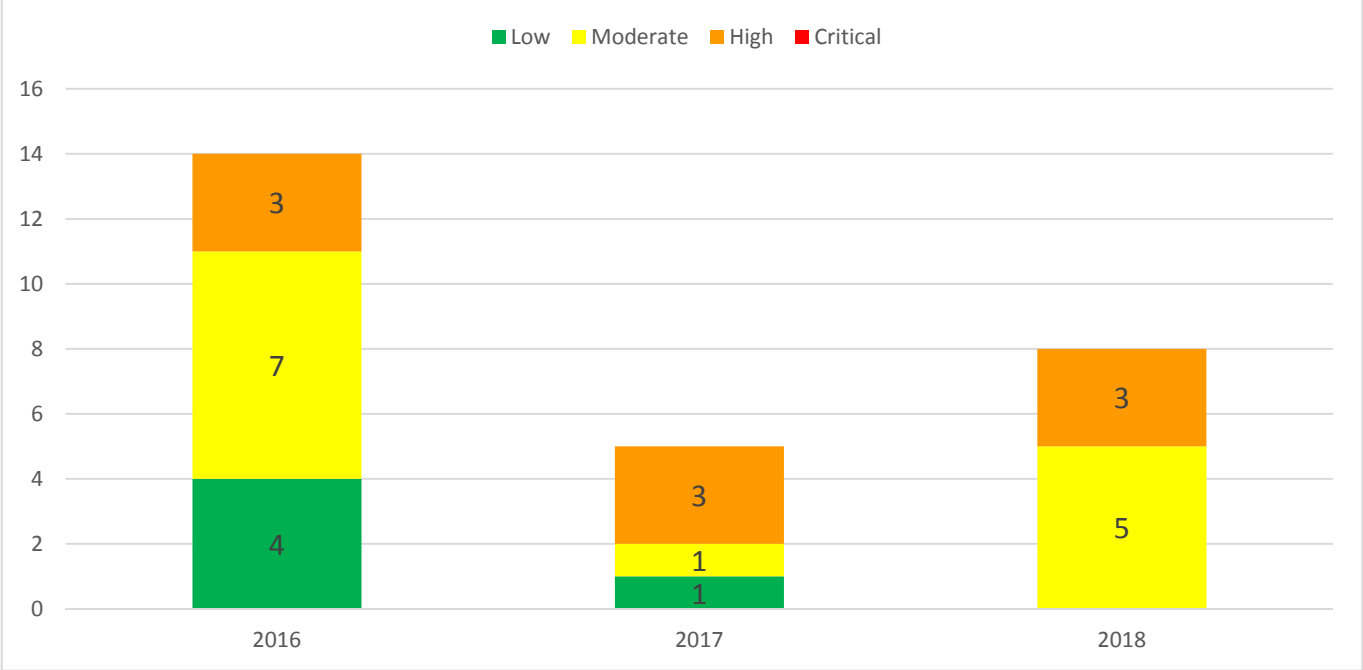
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

Chart 2 – Comparison of overall risk ratings 2016 – 2018



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1.0 Introduction to the Inspection Process

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

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

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

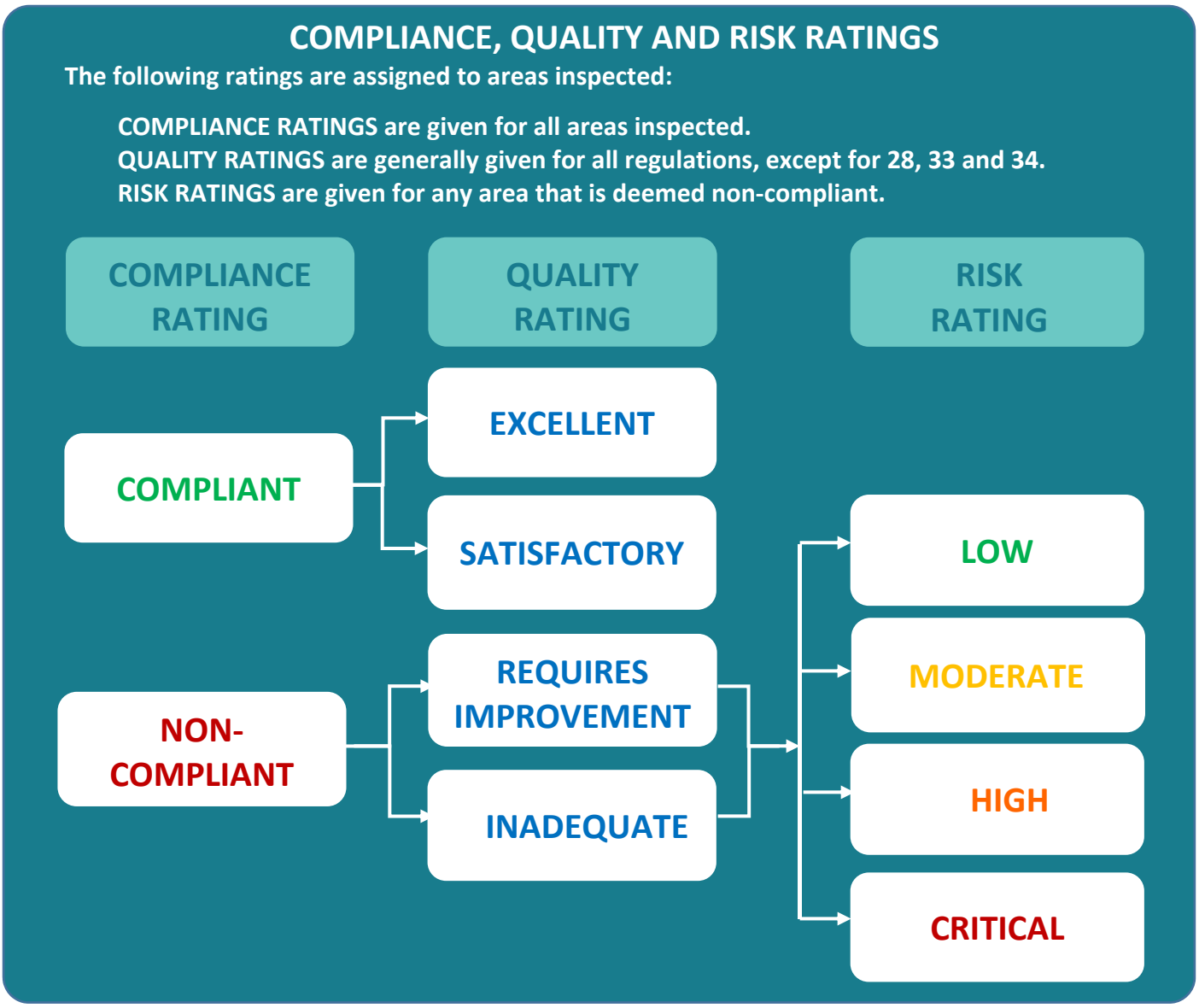
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In Brief

Highfield Hospital was an independent-sector approved centre registered for 111 residents. Highfield Hospital comprised Hampstead Clinic; an eleven-bed acute adult psychiatric unit and five psychiatry of old age units.

Compliance with regulations, rules and codes of practice had improved from 61% in 2016 to 75% in 2018. Five of the standards inspected were rated excellent.

Safety in the approved centre

Although food safety audits had been completed periodically, food temperatures were not recorded in line with food safety recommendations. Food was not prepared in a manner that reduced the risk of contamination, spoilage, and infection. There were a number of deficits in the labelling, prescription and administration of medication, which had the potential to lead to medication errors. Not all health care staff were trained in fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act 2001. Structural risks, including ligature points, were effectively mitigated in the admission unit and in other units through risk assessments of the residents.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary care plan, to which they had input if they were able to do so. The therapeutic services and programmes provided by the approved centre were evidence-based and met the needs of the residents. Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Their special dietary needs were regularly reviewed by a dietitian.

There had been 13 deaths relating to the approved centre since the last inspection. The end of life care provided was appropriate to the residents' physical, emotional, social, psychological, and spiritual needs.

There were a number of breaches of Part 5 of the Mental Health Act 2001 Consent to Treatment.

In one episode of physical restraint, the registered medical practitioner failed to complete a physical examination of the resident within the three-hour stipulated timeframe.

Respect for residents' privacy, dignity and autonomy

Residents were individually risk assessed and decisions regarding any restrictions were discussed by the resident's multi-disciplinary team (MDT) and with the resident, where applicable. Although the residents in Pinel Unit had restricted access to drinking water, due to the risk of falls from spillages, this practice was reviewed at least three monthly. Residents wore their own clothes, could meet visitors in private surroundings, and were free to communicate with whomever they wished. Searches of residents were conducted in a manner respectful of the individuals' privacy and dignity. The environment facilitated residents' privacy.

Responsiveness to residents' needs

Food was presented in an attractive manner and there was a choice of meals. The recreational activities provided by the approved centre were appropriately resourced, with 60 volunteers including gardeners and musicians. Opportunities were provided for indoor and outdoor exercise and physical activity. Information about the approved centre, diagnosis and medication was available in written form. Although complaints were investigated, a systematic record of all complaints relating to the approved centre was not maintained. The approved centre was well maintained and clean throughout.

Governance of the approved centre

The senior management team of the approved centre reported to the Board of Directors and there were clear lines of responsibility throughout the organisation. The person with responsibility for risk, the risk manager, was identified and known by all staff. Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed. Incidents were risk-rated in a standardised format; however, not all medication incidents were recorded. Clinical incidents were reviewed by the MDT at their regular meeting.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A new palliative care room was developed on Farnham and there was ongoing work to provide privacy in the multi-occupancy bedrooms.

2. Bed capacity had increased in Hampstead Clinic with the creation of an additional bed in response to service demand.

3. A music therapist had been appointed in the long-stay units, which recognised the importance of music to the well-being of the residents.

4. A communications officer, whose role was to enhance internal and external communications in Highfield Health Care, had been recently appointed.

5. Partnerships had been established with Dublin City University, University College Dublin and Hibernia College with regard to student nurse education.

6. The approved centre had initiated developments in education, learning and research programmes at Highfield Health Care. An ethics committee had been established with a view to undertaking more research in the approved centre.

7. A peer support group led by AWARE had been implemented in Hampstead Clinic.

8. Residents in Hampstead Clinic had access to the gym and swimming pool in the nearby hotel as a means of enhancing physical well-being and maintaining links with the local community.

9. The volunteer programme had been developed further within Highfield, which complemented the work of the organisation's staff.

10. Lunch and learn sessions were organised regularly in Hampstead Clinic for staff professional development.

11. The approved centre had conducted a staff wellness week since the last inspection to promote mental health and well-being for staff.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Highfield Hospital was an independent-sector approved centre registered for 111 residents. The hospital complex, built in 2010, was located on its own grounds on the Swords Road in Dublin. The original hospital had been established in 1825 by Dr John Eustace, and the hospital was managed by sixth and seventh generations of the Eustace family. The premises were very well maintained, modern, bright and spacious. Highfield Hospital comprised Hampstead Clinic, an eleven-bed acute adult psychiatric unit, and five psychiatry of old age units: Steele, Tuke, Domville, Pinel, and Farnham. Accommodation comprised single, en suite facilities and shared bedrooms. Since the last inspection, the approved centre had included a new palliative care room on Farnham ward and work was ongoing to enhance privacy for residents in the multi-occupancy bedrooms.

Each unit had access to suitable activity and day rooms and well-maintained ground or rooftop gardens. Children were not admitted to the approved centre.

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

Resident Profile	
Number of registered beds	***111***
Total number of residents	**104**
Number of detained patients	6
Number of wards of court	13
Number of children	0
Number of residents in the approved centre for more than 6 months	80
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre had established governance mechanisms in place. The senior management team reported to the Board of Directors and there were clear lines of responsibility throughout the organisation. The approved centre provided the inspection team with copies of the minutes from the Director of Services and Strategic Development meetings, Medical Advisory Committee meetings, Senior Management Team meetings and Quality and Safety Committee meetings. The minutes showed evidence of addressing issues such as service development, business and strategy plans, finance, human resources, and quality and risk management. The governance process addressed both clinical and operational issues relating to the effective functioning of the hospital. Risks were addressed or escalated as required.

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

- Clinical Director
- Director of Nursing
- Senior Social Worker
- Team Lead of the therapy department (Occupational Therapist)
- Quality and Risk Manager
- Head of Human Resources and Operations

Heads of discipline met with the staff from their departments frequently and there were clearly defined line management structures. They were all based in the grounds of the hospital. All departments had staff performance appraisals in line with the approved centre's staffing, recruitment and selection policy.

4.5 Use of restrictive practices

Doors to all units in the approved centre were locked and access was via a swipe card. This process was in place to ensure the safety and welfare of the residents. Residents were individually risk assessed and decisions regarding any restrictions were discussed by the resident's multi-disciplinary team and with the resident, where applicable. Visiting times were flexible to all units.

Residents in Pinel Unit had restricted access to drinking water due to the risk of falls from spillages. Staff were mindful of this practice and ensured that residents were offered regular drinks. Staff reported that this restricted practice was reviewed at least three monthly at the Falls Review Committee meetings.

5.0 Compliance

5.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 6: Food Safety	✗	Moderate	✓		✗	Moderate
Regulation 19: General Health	✗	Moderate	✓		✗	Moderate
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	High	✗	Moderate	✗	Moderate
Regulation 31: Complaints Procedures	✓		✓		✗	High
Part 4 of the Mental Health Act 2001 - Consent to Treatment	✓		✓		✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✓		✗	Moderate
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	Moderate	✗	Low	✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 5: Food and Nutrition
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 14: Care Of The Dying
Regulation 21: Privacy

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
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 Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

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

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.

Eight residents/family/friends met with the inspection team. The residents in Hampstead Clinic were very complimentary of the care and treatment, the staff, the food and the comfortable accommodation. Residents interviewed were involved in their care planning and information regarding their diagnosis and medications was easily available to them.

In the long-term care units, it was felt that there was inconsistency with regard to recreational activities, with less on some days than others. Two people expressed concern as clothes recently purchased had gone missing. Concerns were also raised with regard to the high levels of agency staff at times. Concerns were expressed that there were not enough female staff providing personal care in Tuke Unit, which is an all-female unit. It was mentioned that this issue had improved since last year; however, it appeared to have deteriorated again. Families were complimentary of the care and treatment as well as the food in the long-term care units.

Fourteen residents/family members/friends completed service user experience questionnaires. Eight respondents felt that there were not enough activities during the day. All respondents stated that they felt safe and that their privacy and dignity was respected. Generally, their overall experience was rated highly.

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:

- Chief Executive Officer
- Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Consultant Psychiatrists x 3
- Director of Services
- Quality & Risk Manager
- Head of Human Resources & Operations
- Senior Social Worker

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

There was discussion with regard to the audits, which had not been made available to the inspection team during the inspection process. One hundred and fifty audits had been completed and they were on the electronic system. Appropriate audits were to be forwarded to the inspection team (audits were subsequently received on 20/04/18). There was also discussion regarding Regulation 16 and the lack of therapeutic services and programmes. Feedback from the representatives suggested that this was only temporary and that new staff had been recruited and would be commencing in the near future.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

Training and Education: Not all relevant staff, including medical staff and allied health professionals, had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the identification of residents, as set out in the policy.

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs were used. Resident identifiers, detailed in clinical files, were checked when staff undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to undertaking the provision of therapeutic services and programmes. Two appropriate resident identifiers were not always used prior to administering medications.

The identifiers used were person-specific, and appropriate to the residents' communication abilities. At the time of the inspection, there were no residents with the same or similar name.

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

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

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

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs.

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. In Pinel ward, residents had to request water due to the risk of falls from spillages. This practice was subject to regular review by the approved centre. Hot and cold drinks were offered to residents regularly.

In relation to residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in their individual care plans. Their special dietary needs were regularly reviewed by a dietitian. An evidence-based nutrition tool, The Malnutrition Universal Screening Tool, was used. Residents, their representatives, family, and next of kin were educated about residents' diets, where appropriate, specifically in relation to any contraindications with medication.

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

Regulation 6: Food Safety

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for 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 was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were not recorded in line with food safety recommendations. Specifically, food temperatures in Farnham ward were not logged for teatime meals. Documented analysis had been completed to identify opportunities to improve food safety processes.

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

Food was not prepared in a manner that reduced the risk of contamination, spoilage, and infection. Food scoops were left in dry goods bins on the Farnham ward rather than being separate to foodstuffs, which increased the risk of contamination. This issue had been highlighted in the Environmental Health Officer's inspection of the approved centre in April 2017. Hygiene was not maintained to support food safety requirements, specifically in relation to the storage of chilled meat. There was raw bacon and chicken in the main kitchen's chiller, without a cover.

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

a) **There was no provision of proper facilities for storage in relation to food scoops, 1 (b).**
b) **A high standard of hygiene was not maintained in relation to the storage of chilled meat, 1 (c).**

Regulation 7: Clothing

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in March 2016. The policy included the requirements of the *Judgement Support Framework,* with the exception of the recording the wearing of nightclothes during the day in 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 on residents' clothing. Relevant staff interviewed were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. At the time of inspection, no residents were prescribed to wear nightclothes during the day.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents' clothing was clean and appropriate to their needs. Emergency personal clothing was available that was appropriate and took into account residents' preferences, dignity, bodily integrity, and religious and cultural practices. Funding was also available for emergency personal clothing. Residents had an adequate supply of individualised clothing.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **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 April 2016. The policy addressed all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: Secure facilities were provided for the safe-keeping of residents' monies, valuables, personal property, and possessions, as necessary. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept distinct from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff, and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of two staff issuing the money were retained. Where possible, this was counter-signed by the resident or their representative.

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

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

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

Evidence of Implementation: The approved centre had a recreational coordinator, and volunteers provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. The hospital leaflet given to resident's detailed accessible and user-friendly information on recreational activities, including the type and frequency of activities.

The recreational activities provided by the approved centre were appropriately resourced, with 60 volunteers including gardeners and musicians. Opportunities were provided for indoor and outdoor exercise and physical activity. Activities included walking, films, music, singing, pet therapy, and gardening. Three of the volunteers had trained as physical activity leaders (Care Pals) and provided residents with gentle exercise programs of 20-minute duration.

The communal areas provided were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the resident's clinical file, as appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated excellent was 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 February 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 it reflected the identified needs of the residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre. A small number of residents were Church of Ireland, a smaller number were atheist, and over 90% were Roman Catholic.

Mass was held two to three times a week in Farnham ward. Prayer services occurred once a week in every ward. There were facilities available to support residents' religious practices, including dedicated spaces that could be used as multi-faith rooms. There was a Christian chapel on site that could be used by other faiths. There was a Tabernacle, a copy of the Quran, Holy Bible, and the Hebrew Old Testament.

Residents had access to multi-faith chaplains. There was a resident lay-chaplain available four days weekly. There were Catholic priests and a Church of Ireland minister affiliated with the approved centre from nearby parishes, such as Finglas and Marino. 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 **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in March 2016. The policy included the requirements all 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: At the time of the inspection, no resident had restrictions implemented on their rights to receive visitors. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Appropriate, reasonable, and flexible visiting times were publicly displayed outside of the approved centre and within each unit. Visiting times were also detailed within the resident information booklet.

A separate visitors' room and visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits, and where necessary visits were monitored and supervised.

Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room/areas and facilities available were suitable for visiting children.

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 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in February 2016. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: At the time of inspection, no residents had restrictions on their communication. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: There were no restrictions on residents' communication at the time of the inspection. Residents could use mail, fax, e-mail, telephone, and internet if they wished.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in March 2016. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

Evidence of Implementation: No environmental searches had taken place since the last inspection. The inspection team examined one search of a resident, which had taken place in the approved centre since the previous inspection. Risk had been assessed prior to conducting the search. Resident consent was sought and documented. A written record was maintained of the search.

The resident search policy was communicated to all residents as part of the admission process. For the documented search, it was evident that the resident was informed of the reasons for the search, including what was happening and why. The search was implemented with due regard to the resident's dignity, privacy, and gender. At least one staff member conducting the search was the same gender as the resident being searched.

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Excellent**

(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 in relation to care of the dying, entitled *End of Life Care*, which was last reviewed in May 2016. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Systems analysis had been undertaken in the event of a sudden or unexplained death in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: There had been 13 deaths relating to the approved centre since the last inspection. The end of life care provided was appropriate to the residents' physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of residents were protected. Representatives, family, next of kin, and friends of the residents were involved, supported, and accommodated during end of life care. The residents' deaths were reported to the Mental Health Commission within the required 48-hour time frame.

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 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: There was a policy on individual care plans (ICPs), dated July 2016. The policy included all of the criteria of the *Judgement Support Framework.*

Training and Education: Not all clinical staff, specifically medical staff, had signed a log to indicate that they had read and understood the policy on individual care planning. All clinical staff interviewed articulated the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members were trained in individual care planning.

Monitoring: ICPs were audited on a monthly basis to assess compliance with the regulation. Analysis was completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: Each resident had an ICP. All ICPs inspected were a composite set of documentation detailing goals, treatment, care, and resources required. The documentation stored within each resident's clinical file was identifiable, uninterrupted, and not amalgamated with progress notes. A key worker was identified in all residents' ICPs or in their clinical files.

Each resident in the approved centre had been assessed at admission by the admitting clinician and an initial ICP was developed. The ICPs for residents in Hampstead Clinic were developed by the MDT following a comprehensive assessment within seven days of admission. Evidence-based assessments were used.

The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate in Hampstead Clinic. In the care of the elderly wards, the ICP was drawn up with the family of the resident when the resident was unable to attend. Residents were informed of the outcome of the ICP meeting and any proposed changes. Residents in Hampstead Clinic were not routinely invited to attend the ICP meeting, which was held twice a year.

The ICPs identified appropriate goals, care and treatment, and interventions and specified the resources required to provide the care and treatment identified. The MDTs reviewed ICPs weekly. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances, and goals. This was documented every six months.

The ICPs did not include a preliminary discharge plan in the ICPs inspected in Hampstead Clinic. There was a pro forma for the discharge plan to be used when the resident was being discharged, but there was no prompt on the MDT review pro forma to denote if discharge had been discussed or not at the weekly meeting.

The residents had access to their ICPs and were kept informed of any changes. Two residents were not offered a copy of their ICPs, including any reviews. When a resident declined or refused a copy of their ICP, this was not recorded, nor was the reason why recorded.

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

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

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

A list of all therapeutic services and programmes provided in the approved centre was available to all residents. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. These included dietetics, speech and language therapy, and tissue viability nursing.

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

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A log of transfers was not 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 examined. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented.

Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks. There was a record to indicate the resident's accompaniment requirements on transfer. The resident was risk assessed prior to the transfer.

Written information was issued with copies retained as part of the transfer, including a resident transfer form, and the required medication for the resident during the transfer process. A letter of referral, including a list of current medications was not issued or retained. A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility.

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, monitoring, and evidence of implementation pillars.

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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. The policy was last reviewed in August 2016. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Residents' take-up of national screening programmes was not 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 resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED), which was kept at reception. The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

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

One out of the five six-monthly general health assessments inspected documented a physical examination and the resident's weight only. It did not document family/personal history, Body Mass Index, waist circumference, blood pressure, smoking status, nutritional status (diet and physical activity, including sedentary lifestyle), medication review (per prescriber guidelines), and dental health, as required. There were no residents on antipsychotic medication at the time of the inspection.

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

Residents had access to national screening programmes appropriate to age and gender. Not all wards had equal access to information on national screening programmes.

There was a localised policy on tobacco use, which related to the facilitation of smoking.

The approved centre was non-compliant with this regulation due to their failure to ensure that one general health assessment fulfilled the complete criteria stipulated by the Mental Health Commission, 19, 1 (b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in November 2016. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

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

There were also regular family newsletters available on each unit and at the main reception. Information pamphlets on different illness, advocacy groups, support groups and general information were dispersed throughout the approved centre. Notices boards displayed relevant information in relation to activities such as recreational pursuits, church services and related spiritual services.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or

mental health, well-being, or emotional condition. At the time of the inspection, there were no restrictions on information regarding a resident's diagnosis applied to any resident.

Medication information sheets as well as verbal information were provided in a format appropriate to the residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the residents, including any possible side-effects. Residents had access to interpretation and translation services when needed.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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 April 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The general behaviour of staff and the way in which staff addressed and communicated with residents was respectful. Residents were dressed appropriately to ensure their privacy and dignity. Staff wore distinctive uniforms, which indicated their discipline.

All single bedrooms, bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Where residents shared a room, bed screening was appropriate to ensure their privacy was not compromised.

Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls through their own personal phones, where appropriate. There were portable phones available in each unit to facilitate private communication.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to its premises.

Training and Education: There was no policy in place for staff to read and articulate.

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

Evidence of Implementation: The approved centre's building was five years old at the time of the inspection. Accommodation for each resident assured their comfort and privacy. All bedrooms were appropriately sized to meet residents' needs. There was a sufficient number of toilets and showers for residents. Communal rooms were of adequate size, and suitable furnishings were provided to support resident independence and comfort.

The approved centre was adequately lit, heated, and ventilated. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised.

The approved centre was kept in a good state of repair externally and internally, and it was clean, hygienic, and free from offensive odours. There was a programme of general maintenance, decorative

maintenance, cleaning, decontamination, and repair of assistive equipment in place. A record of this programme was maintained. Remote or isolated areas of the approved centre were monitored.

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

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were not always recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had a Medication Prescription and Administration Record (MPAR), and the prescription record was separate. Records of ten residents were inspected. Each MPAR and prescription evidenced a record of medication management practices, records of all medications administered, and details of route, and frequency of medication. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was present within each resident's prescription.

MPARs did not include a record of two resident identifiers on the MPAR sheets for new medications, and medications where the dose had changed. New MPAR sheets had detailed only one resident identifier. Four sheets had unsigned dates of discontinuation of medication, and two MPARs did not record the discontinuation date for each medication. Old medication sheets were contained within the MPAR, and the doctor signed the old medication sheet instead of the new medication sheet. In one medication record, one medication was not given the day before the discontinuation date of the medication. This was not documented as withheld medication or refused medication.

The brand name was recorded for medication instead of the generic name. In one case, a medicine label was altered instead of being rewritten by the registered medical practitioners. In one MPAR, the MCRN was illegible. In one case, a label on the MPAR and blister pack was different from the prescription.

All entries in the MPAR were written in black indelible ink. The expiration date of the medication was checked prior to administration, and expired medications were not administered.

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

Medication dispensed or supplied to the resident was stored securely in a locked storage unit, or fridge where appropriate. The medication administration cupboard remained locked at all times and secured in a locked room. The emergency tray of medication was a box, and it was unlocked in an unlocked storeroom at the time of the inspection. During the course of the inspection, this emergency tray was moved to a locked clinical room instead.

Refrigerators used for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose of medication, the quantity of medication, and expiry date.

Medications that were no longer required, were past their expiry date or had been dispensed to a resident but were no longer required, were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was non-compliant with section one of the regulation because:

a) **MPARs did not include a record of two resident identifiers on MPARs for new medications, and medications where the dose had changed. New MPARs had detailed only one resident identifier.**
b) **The brand name was recorded for medication instead of the generic name. In one case, a medicine label was altered instead of being rewritten by the registered medical practitioners.**
c) **Four sheets had unsigned dates of discontinuation of medication, and two MPARs did not record the discontinuation date for each medication. Old medication sheets were contained within the MPAR, and the doctor signed the old medication sheet instead of the new medication sheet.**
d) **In one medication record, one medication was not given the day before the discontinuation date of the medication. This was not documented as withheld medication or refused medication.**
e) **In one case, a label on the MPAR and blister pack was different from the prescription.**
f) **In one MPAR, the MCRN was illegible.**

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 series of written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in April 2017. The policies addressed all the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its recruitment, selection and vetting of staff. The policy was last reviewed in August 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 relating to staffing, as set out in the policy.

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

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

A written staffing plan was available within the approved centre. Staff were trained in areas such as manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management, incident reporting, the protection of children and vulnerable adults, and recovery-centred approaches to mental health care and treatment.

Not all health care staff were trained in the following:

- Fire safety
- Basic Life Support
- Management of violence and aggression (MAPA)
- The Mental Health Act 2001.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) 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. Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff and there were support mechanisms in place such as tuition support, scheduled time away from work, or recognition for achievement.

All staff training was documented and staff training logs were maintained. The following is a table of clinical staff assigned to the approved centre.

Ward or Unit	*Staff Grade*	*Day*	*Night*
Hampstead Clinic	CNM3	1 (Mon-Fri)	0
	RPN	2	2
	HCA	0	0
Ward or Unit	*Staff Grade*	*Day*	*Night*
Steele	CNM1	1	0
	RPN	1	1
	HCA	1	1
Ward or Unit	*Staff Grade*	*Day*	*Night*
Tuke	CNM1	1	0
	RPN	1	1
	HCA	3	1
Ward or Unit	*Staff Grade*	*Day*	*Night*
Domville	CNM1	1	0
	RPN	1	1
	HCA	1	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 staff had up-to-date mandatory training in Basic Life Support, fire safety, MAPA, 26(4).

Ward or Unit	Staff Grade	Day	Night
Pinel	CNM1	1	0
	RPN	1	1
	HCA	3	1

Ward or Unit	Staff Grade	Day	Night
Farnham	CNM1	1	0
	RPN	1	1
	HCA	3	2

There was an additional staff nurse and a HCA across all wards at night

Consultant Psychiatrist	3.75 WTE (whole time equivalent)
Non-consultant Hospital doctors	2 WTE
Psychologist	1 WFE for Hamstead Clinic
Occupational Therapist (OT)	1 WFE for long-term care and 16 hours per week for Hampstead
Social Worker	2 WFE across the AC
Physiotherapist	16 hours per week for long-term care
Music Therapist	20 hours per week for long-term care
Art Therapist	12 hours per week for Hamstead Clinic
OT Assistant	1 WFE for long-term care

b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 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. The policy was last reviewed in April 2017. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Resident records were reflective of the residents' current status and the care and treatment being provided. All residents' records were secure, up to date, in good order, with no loose pages, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were physically stored together, where possible, and some records were stored on the Epicare computer system.

Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation. Only authorised staff made entries in residents' records, or specific sections therein. Hand-written records were legible and written in black indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. The 24-hour clock was detailed in each entry of residents' records.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Residents' access to their records was managed in accordance with the Data Protection Acts. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in July 2017. It included all of the requirements the *Judgement Support Framework* with the exception of the process for making obsolete and retaining previous versions of operating policies and procedures.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. There was no evidence to indicate that relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines. The format of the operating policies and procedures was standardised. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in May 2016. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff, specifically medical staff, had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

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

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

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

Regulation 31: Complaints Procedures

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in April 2016. The policy 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 the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed. Required actions to improve processes were not identified.

Evidence of Implementation: The nominated person, the Director of Nursing, was responsible for dealing with all complaints in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed and also detailed within the resident information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service and care and treatment of a resident was not adversely affected by reason

of the complaint being made. A method for addressing minor complaints within the approved centre was provided.

Where minor complaints could not be addressed locally, the nominated person dealt with the complaint, but there was no documentation of the complaint or the escalation process, where appropriate. The complainant's satisfaction or dissatisfaction with the investigation findings was not clearly and consistently documented in a recorded response. Timeframes to resolve complaints were not pre-defined or specific, but were dependent on the type of investigation or extension required.

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

The approved centre was non-compliant with this regulation because a systematic record of all complaints relating to the approved centre was not maintained, 31 (6).

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 two separate written policies in relation to risk management and incident management procedures. The risk management policy was last reviewed in March 2018, and the incident reporting policy was last reviewed in April 2016. The policies addressed all of the requirements of the *Judgement Support Framework.*

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. Managers were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

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

Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at admission, before and during episodes of physical restraint and mechanical restraint, at resident transfer, at resident discharge, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Residents and/or their representatives were not involved in individual risk management processes.

Structural risks, including ligature points, were effectively mitigated in the admission unit and in other units through risk assessments of the residents. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format; however, not all medication incidents were recorded. Clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and recommended actions.

There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently outside each of the wards 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 Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

The clinical files of two residents who had been mechanically restrained for two episodes each were inspected. The approved centre complied with Part 5 of the Rules Governing the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others, across all four episodes.

Mechanical restraint was only used when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need, and it was only used when less restrictive alternatives were not suitable. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist acting on his/her behalf.

Each clinical file contained a contemporaneous record that specified the following:

- That there was an enduring risk of harm to self or to others.
- That less restrictive alternatives were implemented without success.
- The type of mechanical restraint.
- The situation where mechanical restraint was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The approved centre was compliant with this rule.

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of five involuntary patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication for over three months were examined.

Two patients consented to receiving treatment. This was documented. There were three patients who were considered unable to consent to receiving treatment and this was also documented.

In relation to the two patients who consented to receiving treatment, a written record of consent had been completed, but the following discrepancies were found on inspection:

- In two cases, it was stated that the patient had consented to treatment but there was no documented evidence to show that the responsible consultant psychiatrist had undertaken a capacity assessment or the equivalent.

- In one case, the written record of consent did not specifically name the medications prescribed. Instead, the terms “antipsychotic” and “antidepressant” were used.
- In one case, the written record did not detail the discussion with the patient about the nature and purpose of the medications, and the beneficial effects of the medications.

These discrepancies were remedied at the time of inspection.

Three patients were unable to consent to receiving treatment and this was documented. In all cases, a *Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* had been completed. Each Form 17 included details of the names of the medications prescribed, and any views expressed by the patients were recorded. In each case, authorisation was provided by a second consultant psychiatrist.

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

a) In two cases, it was stated that the patient had consented to treatment but there was no documented evidence to show that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent.
b) In one case, the written record of consent did not specifically name the medications prescribed. Instead, the terms “antipsychotic” and “antidepressant” were used.
c) In one case, the written record did not detail the discussion with the patient about the nature and purpose of the medications, and beneficial effects of the medications.
d) In relation to a patient who was not able to consent to receiving treatment, it was stated that they did not have capacity to consent but there was no documented evidence to show that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. Physical restraint was not used to ameliorate staff shortages. The policy was reviewed annually; and it was last reviewed in March 2018. The policy addressed the following:

- The provision of information to the resident.
- Those who can initiate and implement physical restraint.

Training and Education: The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy.

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

Evidence of Implementation: There was only one documented episode of physical restraint since the last inspection. The clinical file of one resident was reviewed. A designated staff member was responsible for leading the physical restraint of the resident, and for monitoring the head and airway of the resident.

The resident was informed of reasons for, likely duration of, and circumstances leading to, discontinuation of physical restraint. The resident's next of kin/representative was informed of the use of physical restraint. The physical restraint episode lasted for a maximum of 30 minutes, and a same sex staff member was present while the resident was being physically restrained.

There was no documented indication that the consultant psychiatrist was notified about the physical restraint episode. The registered medical practitioner completed a physical examination of the resident outside of the three hour stipulated time frame. The assessment was completed 20 hours after the physical restraint episode. The completed clinical practice form was placed in the resident's clinical file. The episode of physical restraint was reviewed by members of the multi-disciplinary team, and documented in the clinical file no later than two working days after the episode of physical restraint.

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

a) **There was no documented indication that the consultant psychiatrist was notified about the physical restraint episode, 5.3.**
b) **The registered medical practitioner completed a physical examination of the resident outside of the three hour stipulated time frame. The assessment was completed 20 hours after the physical restraint episode, 5.4.**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. All of the policies were reviewed in February 2017, and all policies included all of the policy related criteria of the code of practice.

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

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

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

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental health illness or mental disorder. The decision to admit was made by the registered medical practitioner (RMP)/consultant psychiatrist. The resident was assigned a key-worker. The resident had two admission assessments, one completed by the nurse, and the second assessment completed by the doctor. The resident's family member/carer/advocate was involved in the admission process, with the resident's consent. The admission assessment was comprehensive, and it included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information. This included work situation, education and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

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

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

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

a) **Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies, 9.1.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 6: Food Safety

Report reference: Pages 19 & 20

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. There was no provision of proper facilities for storage in relation to food scoops, 1 (b).	*New*	Corrective Action(s): New scoops have been procured to ensure single product use and ensure no cross - usage. Scoops will be stored and used appropriately. Post-Holder(s) responsible: Catering Manager	Audit/Spotchecks	Achievable	October 2018
		Preventative Action(s): Training and awareness sessions for Catering staff and Health Care Assistants will be scheduled. Oversight and monitoring of this issue will be ensured through audits and spot checks. Post-Holder(s) responsible: Catering Manager / CNM1's	Audit/Spotchecks and training records.	Achievable	December 2018
2. A high standard of hygiene was not maintained in relation to the storage of chilled meat, 1 (c).	*New*	Corrective Action(s): Chilled meat will be appropriately packaged in smaller quantities in air tight containers and stored in the under counter fridge in the main kitchen with dates visible. Post-Holder(s) responsible: Catering Manager	Audit	Achievable	October 2018 - completed

		Preventative Action(s): Awareness sessions for catering staff on food storage will be scheduled. Post-Holder(s) responsible: Catering Manager	Awareness session records.	Achievable	December 2018

Regulation 19: General Health

Report reference: Page 36 & 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. The approved centre was non-compliant with this regulation due to their failure to ensure that one general health assessment fulfilled the complete criteria stipulated by the Mental Health Commission, 19, 1 (b)	*New*	Corrective Action(s): The general health assessment template was revised following inspection to incorporate good practice guidance issued in Febraury 2018 in JSF Version 5. Post-Holder(s) responsible: CNM3	Audit	Achievable	April 2018 - Completed
		Preventative Action(s): The general assessment includes all required parameters. A staff nurse will accompany the doctor for general health assessments to ensure all relevant information is captured at the time of assessment. Post-Holder(s) responsible: CNM3	Audit	Achievable	Commenced in May 2018 and ongoing

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

Report reference: Page 43 & 44

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. MPARs did not include a record of two resident identifiers on MPARs for new medications, and medications where the dose had changed. New MPARs had detailed only one resident identifier. 5. The brand name was recorded for medication instead of the generic name. In one case a medicine label was altered instead of being rewritten by the registered medical practitioners. 6. In one MPAR the MCRN was illegible.	*Reoccurring – Provide plan to address deficiencies in the MPAR*	Corrective Action(s): An electronic medication management system is being rolled out in the long – stay units. A revised medication booklet for the acute services has also been developed. Both include the requisite number of resident identifiers, the generic medication preparation and the MCRN. Post-Holder(s) responsible: Director of Nursing/ CNM3/Clinical Director	Audit	Achievable	March 2019
		Preventative Action(s): The new system will be evaluated and monitored. Post-Holder(s) responsible: Director of Nursing/ CNM3	Spotchecks / Audit	Achievable	March 2019
7. Four sheets had unsigned dates of discontinuation of medication, and two MPARs did not record the discontinuation date for each medication. Old medication sheets were contained within the MPAR, and the doctor signed the old medication sheet instead of the new medication sheet. 8. In one medication record, one medication was not given the day before the	*Reoccurring – Provide plan to address deficiencies in process for discontinuation*	Corrective Action(s): This issue was raised at the Medical Advisory Committee (MAC). The introduction of an Electronic Medication Management system which is being rolled out in the long – stay units and the revised updated medication booklet (MPARS) in the acute services will address these issues. Post-Holder(s) responsible: Clinical Director	Spotchecks / Audit	Achievable	March 2019

discontinuation date of the medication. This was not documented as withheld medication or refused medication.		Preventative Action(s): This issue is discussed at the MAC meetings. Regular checks now occur at MDT meetings to highlight any actions required in this area. Post-Holder(s) responsible: Clinical Director / CNM's	Spotchecks / Audit	Achievable	October 2018
9. In one case a label on the MPAR and blister pack was different from the prescription.	*New*	Corrective Action(s): The electronic medication management system is linked directly to the dispensing pharmacy and will address this issue. Post-Holder(s) responsible: Clinical Director	Spotchecks / Audit	Achievable	March 2019
		Preventative Action(s): Nursing staff carry out medication checks on receipt from pharmacy. Post-Holder(s) responsible: CNM's	Spotchecks / Audit	Achievable	October 2018

Regulation 26: Staffing

Report reference: 46 – 48

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
10. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, 26(4 11. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccuring*	Corrective Action(s): Outstanding staff to complete BLS, fire safety, MAPA and MHA training. Mandatory training classes scheduled. Post-Holder(s) responsible: Assistant Director of Nursing / Head of HR	Training records	Achievable	January 2019
		Preventative Action(s): Ongoing monitoring of completion of mandatory training and report generation with appropriate escalations. Post-Holder(s) responsible: Director of Nursing / Head of HR	Time management system (TMS) training monthly reports.	Achievable	January 2019

Regulation 31: Complaints Procedures

Report reference: 54-55

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
12. The approved centre was non-compliant with this regulation because a systematic record of all complaints relating to the approved centre was not maintained, 31 (6).	New	Corrective Action(s): Review of current processes has taken place and a new electronic system to systematically manage complaints will be introduced . Post-Holder(s) responsible: Director of Nursing/ Quality & Risk Manager	Review of records	Achievable	January 2019
		Preventative Action(s): A new electronic system of reporting all complaints will be introduced. Post-Holder(s) responsible: Director of Nursing/ Quality & Risk Manager	Review of records	Achievable	January 2019

Code of Practice: Consent to Treatment

Report reference: 63 - 64

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
13. In one case, the written record of consent did not specifically name the medication(s) prescribed. Instead, the terms "antipsychotic", and "antidepressant", were used.	*New*	Corrective Action(s): This was rectified during the inspection. Post-Holder(s) responsible: Consultant Psychiatrists / Clinical Director	From 17 review	Achievable	April 2018 - Completed
		Preventative Action(s): The Consultant is aware of the MHC feedback on this issue. Post-Holder(s) responsible: Consultant Psychiatrists / Clinical Director	Form 17 Review	Achievable	April 2018 - Completed
14. In two cases it was stated that the patient had consented to treatment but there was no documented evidence to show that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent. 15. In relation to a patient who was not able to consent to receiving treatment, it was stated that they did not have capacity to consent but there was no documented evidence to show that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent.	*New*	Corrective Action(s): This was rectified during the inspection. Post-Holder(s) responsible: Consultant Psychiatrists / Clinical Director	Review of documentation / Audit	Achievable	April 2018 - Completed
		Preventative Action(s): The capacity form has been revised to reflect the feedback from the MHC. Post-Holder(s) responsible: Consultant Psychiatrists / Clinical Director	Review of documentation / Audit	Achievable	April 2018 - Completed
16. In one case the written record did not detail the discussion with the patient, about the nature and purpose(s) of the medication (s), and the beneficial effects of the medication(s).	*New*	Corrective Action(s): This was rectified during the inspection. Post-Holder(s) responsible: Consultant Psychiatrists / Clinical Director	Review of documentation / Audit	Achievable	April 2018 - Completed

		Preventative Action(s): The capacity form has been revised to reflect the feedback from the MHC. Post-Holder(s) responsible: Consultant Psychiatrists / Clinical Director	Review of documentation / Audit	Achievable	April 2018 - Completed

Code of Practice: Use of Physical Restraint

Report reference: Page 66

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
17. There was no documented indication that the consultant psychiatrist was notified about the physical restraint episode, 5.3.	New	Corrective Action(s): Nursing staff have been made aware of their responsibility in relation to notifying the consultant psychiatrist Post-Holder(s) responsible: DON	Audit	Achievable	Ongoing
		Preventative Action(s): This item is included on the physical restraint checklist. This is now referred to as part of MAPA training for staff. Post-Holder(s) responsible: CNM3	Review of documentation / Audit	Achievable	Ongoing
18. The registered medical practitioner completed a physical examination of the resident outside of the three hour stipulated timeframe. The assessment was completed 20 hours after the physical restraint episode, 5.4.	New	Corrective Action(s): Highfield Hospital has a new SLA with medical contractors to provide an out of hours service that will satisfy the requirements of the Code of Practice. Post-Holder(s) responsible: Clinical Director	Review of documentation / Audit	Achievable	October 2018
		Preventative Action(s): Highfield Hospital has a new SLA with medical contractors to provide an out of hours service that will satisfy the requirements of the COP. Post-Holder(s) responsible: Clinical Director	Review of documentation / Audit	Achievable	October 2018

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 67 & 68

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
19. Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies, 9.1.	New	Corrective Action(s): All relevant staff have been informed to sign the policy log. Guidance on completion of electronic signing of policies has been issued. Post-Holder(s) responsible: ADON/ CNM's	Review policy log	Achievable	December 2018
		Preventative Action(s): Signing of policies to be discussed at change of shift staff handovers. Post-Holder(s) responsible: ADON/ CNM's	Review policy log	Achievable	Ongoing