Lois Bridges

ID Number: AC0079

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Lois Bridges
3 Greenfield Road
Sutton
Dublin 13

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
19 January 2016

Conditions Attached:
Yes

Registered Proprietor:
Ms. Melanie Wright

Registered Proprietor Nominee:
N/a

Inspection Team:
Dr Enda Dooley, MCRN 004155, Lead Inspector
Mary Connellan
Karen McCrohan

Inspection Date:
6 - 9 November 2018

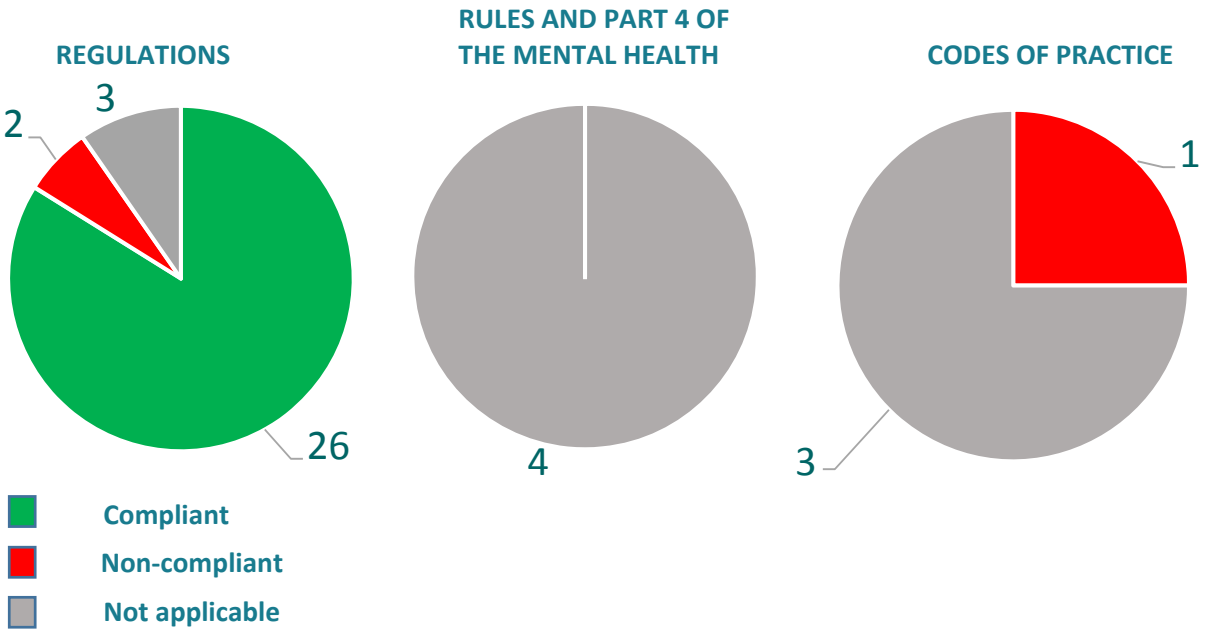
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
21 - 24 March 2017 – Annual Inspection
17 – 18 August 2017 – Focused Inspection
5 – 6 December 2017 – Focused Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
14 February 2019

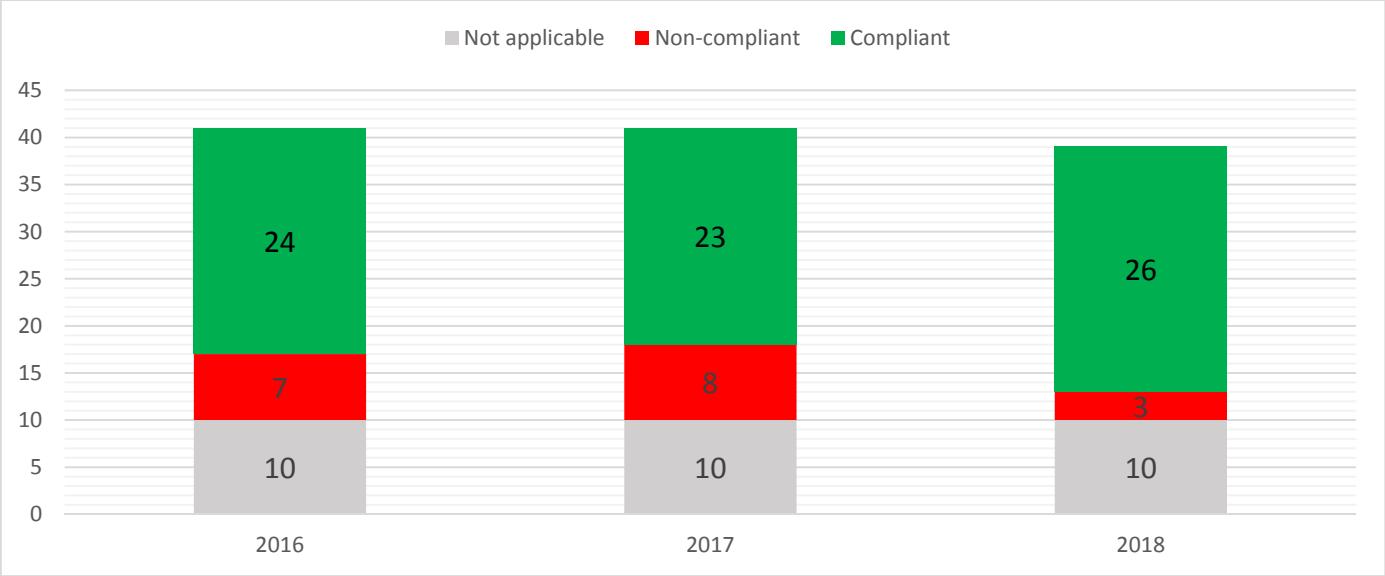
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

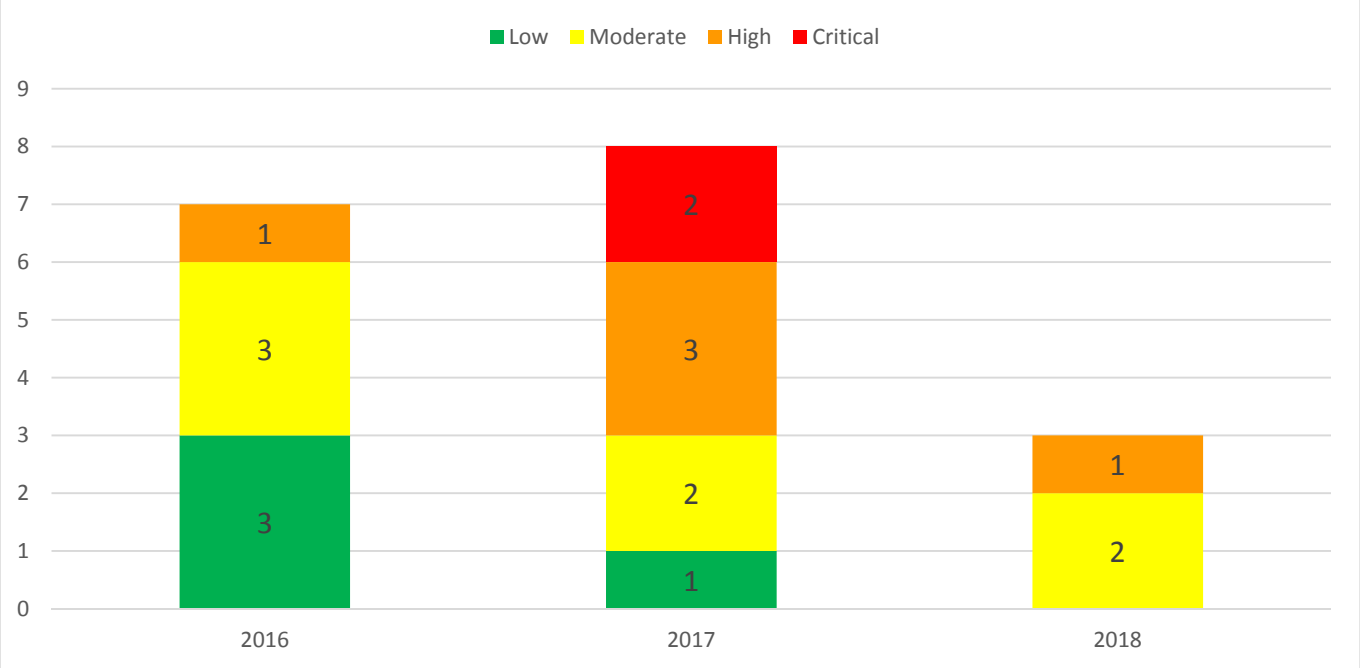
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018



Contents

1.0 Introduction to the Inspection Process

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

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

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

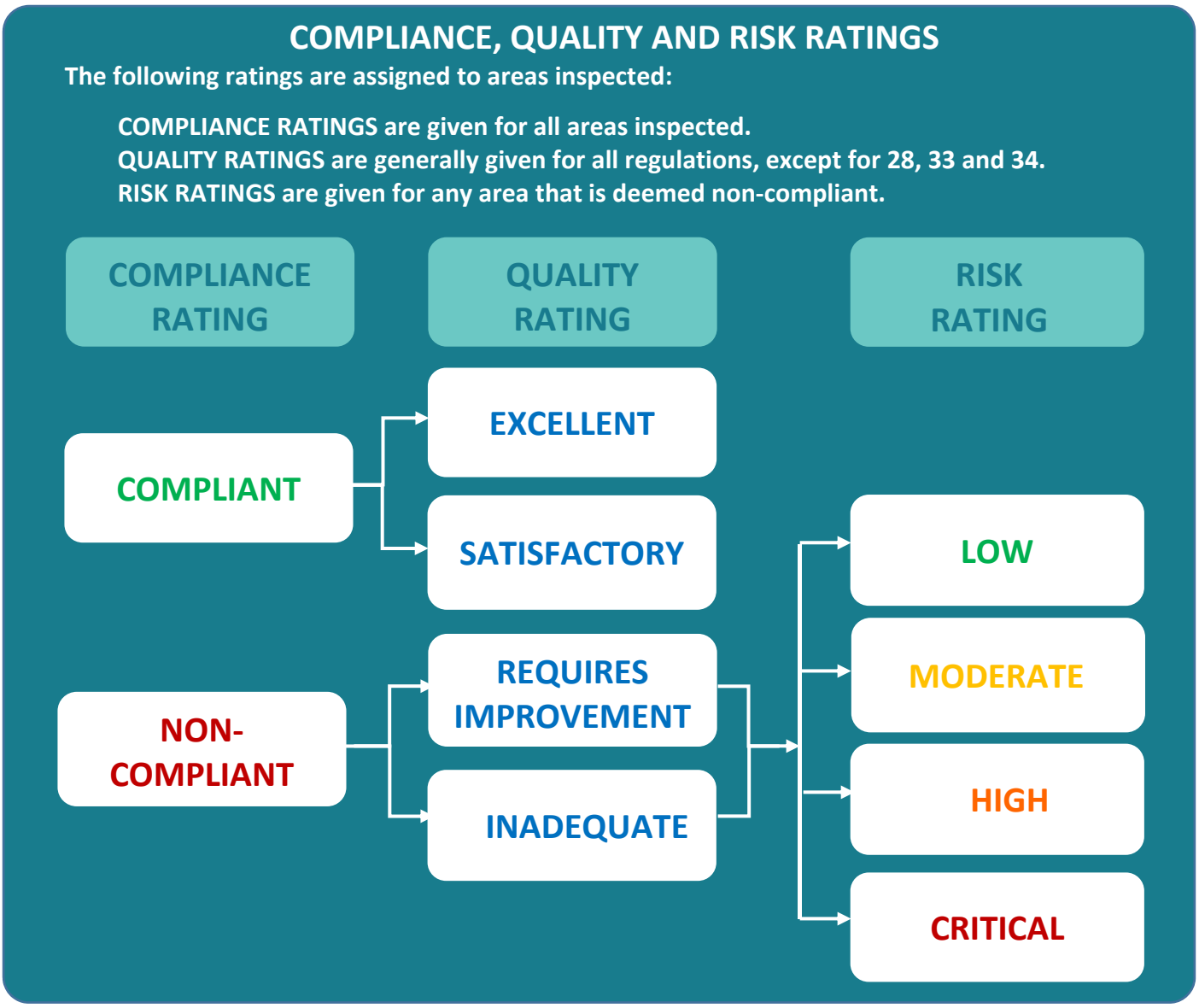
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

Lois Bridges was a for profit independent 7-bed approved centre for eating disorders. It was situated in a suburb of Dublin in what was previously a residential house. Involuntary patients were not admitted and the approved centre only accepted planned admissions.

There were three conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: The approved centre must develop and implement protocols and procedures for the admission of residents, including detailed exclusion criteria reflective of the service provided.

Condition 2: The approved centre must develop and implement protocols and procedures to ensure access to necessary services and specialists, including but not limited to a gastroenterologist and daily blood testing.

Condition 3: The approved centre is not permitted to admit a high risk resident; with a Body Mass Index (BMI) of less than 13.

These had been attached due to concerns in previous inspections by the Inspector regarding the safety of residents in the approved centre. During the course of this inspections, the inspectors found that these conditions had been met.

There was an improvement in compliance with regulations, rules and codes of practice from 74% in 2017 to 90% in 2018. Two compliances with regulations had been rated as excellent.

Safety in the approved centre

Individual risk assessments were completed at resident admission and discharge as well as in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained but were effectively mitigated. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Food audits were carried regularly and all food preparation and storage area were

clean. There were a small number of errors in the administration and prescription of medications that could potentially lead to medication errors. All health care staff were trained in fire safety, Basic Life Support, management of violence and aggression, the Mental Health Act 2001 and Children First.

Appropriate care and treatment of residents

Each resident had an individual care plan which was developed and reviewed with the multi-disciplinary team and the resident. Therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate to the assessed needs of the residents, as documented in the residents' individual care plans. Each resident had a nutritional assessment by a dietician and an individual dietary plan. General health was assessed by a general practitioner on admission and as required thereafter. Each resident had an assessment by a gastroenterologist prior to admission. As the approved centre had stopped admitting residents with severe anorexia, the need to transfer seriously ill residents as an emergency to local hospitals had ceased at the time of inspection.

The clinical file of one discharged resident contained clinical documentation pertaining to another resident and that the approved centre had insufficient written policies and procedures, specifically in relation to the creation of records. There were a small number of deficiencies in the admission, transfer and discharge policy but admissions and discharges were carried out in accordance with the relevant code of practice.

Respect for residents' privacy, dignity and autonomy

Residents wore their own clothes and maintained control over their own property. Searches were carried out with the resident's permission and with due regard to their privacy and dignity. There was a visiting room which guaranteed privacy and there were flexible visiting times. All bedrooms were locked from 8.30 am to 7 pm as part of the residents' care and treatment. If residents required access to their bedroom during the day, this was facilitated under the supervision of staff. There were five single bedrooms and one double bedroom which had screening in place.

Responsiveness to residents' needs

A wide range of recreational activities were available. There was access to religious services if desired. There was free access to mobile phones and the internet. The approved centre was well maintained and clean, with a pleasant private garden. Written information about the approved centre, medication and diagnosis were readily available and a complaints process was in place.

Governance of the approved centre

There was significant improvement in the governance processes since last inspected. The Management Team, consisting of the Registered Proprietor, Director of Services, and Clinical Nurse Manager, met approximately every two months. Minutes indicated an active governance process including matters relevant to recruitment and retention of staff, risk management including review of the risk register, and training issues. In addition, the approved centre had a Health and Safety committee which met quarterly and a documented staff meeting process. These various processes and groups had significantly enhanced oversight and risk review processes within the approved centre.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register, which was regularly reviewed.

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

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Monthly Eating Disorders Education for Families session introduced.

2. Structured discharge planning process introduced.

3. Active Risk Management process developed and initiated.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Lois Bridges was located close to the centre of Sutton village in north Dublin. The approved centre consisted of a large detached residence with surrounding gardens. An additional building within the rear garden area provided office, laundry, and a therapy space. Accommodation with the main house consisted of five single bedrooms and a two-bedded room. Two of the bedrooms were en suite. Residents also had access to two communal bathrooms. In addition, there was an open-plan kitchen and dining room with attached sitting area, a therapy room, and a small sitting room which was also used for meetings. The approved centre was homely and domestic and provided adequate space for resident recreation.

Lois Bridges was an independently owned and managed facility which provided care and treatment for up to seven adults with eating disorders. Admissions were planned and the centre did not admit people on an involuntary basis. All admissions were under the care of the clinical director of Lois Bridges.

Resident care was co-ordinated by the Director of Services. Residents had access to a therapeutic programme based predominantly on individual or group therapies which were provided by a range of contracted therapists on a sessional basis. All residents had a specialist gastroenterology assessment prior to admission. Residents were medically assessed by a local GP who also provided on-going general medical support.

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

Resident Profile	
Number of registered beds	***7***
Total number of residents	**7**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

There were three conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: Pursuant to Section 64(6)(b)(v) of the Mental Health Act 2001 the approved centre must develop and implement protocols and procedures for the admission of residents, including detailed exclusion criteria reflective of the service provided.

Condition 2: Pursuant to Section 64(6)(b)(v) of the Mental Health Act 2001 the approved centre must develop and implement protocols and procedures to ensure access to necessary services and specialists, including but not limited to a gastroenterologist and daily blood testing.

Condition 3: Pursuant to Section 64(6)(a)(i) of the Mental Health Act 2001 the approved centre is not permitted to admit a high risk resident; with a Body Mass Index (BMI) of less than 13.

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 significantly augmented its governance processes since last inspected. The Management Team, consisting of the registered proprietor, director of services, and clinical nurse manager, met approximately every two months. Minutes of these meetings were provided to the inspection team. These indicated an active governance process including matters relevant to recruitment and retention of staff, risk management including review of the risk register, and training issues. In addition, the approved centre had a Health and Safety committee which met quarterly and a documented Staff Meeting process. These various processes and groups had significantly enhanced oversight and risk review processes within the approved centre.

4.5 Use of restrictive practices

All bedrooms were locked from 8.30am to 7pm as part of the residents' care and treatment. If residents required access to their bedroom during the day this was facilitated under the supervision of staff

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 23: Ordering, Prescribing, Storing & Administration of Medicines	✓		✗	High	✗	High
Regulation 27: Maintenance of Records	✗	Low	✗	Low	✗	Moderate
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	High	✗	High	✗	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 6: Food Safety	

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.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.

Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As the approved centre did not use physical restraint, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable
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.

Four service users, including a day patient, met with the inspection team. Residents expressed satisfaction with their care and treatment. Some expressed a view that, for seven people, the accommodation was somewhat limited. This reservation was not deemed of any major significance by those expressing it. In addition to those residents who met with the inspection team four residents returned questionnaires regarding their experience. All expressed satisfaction and no concerns were raised.

7.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Director of Services
- Risk Advisor
- Clinical Nurse Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. A number of clarifications regarding various aspects of the inspection process were offered during the feedback and immediately after.

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 October 2016. The policy included the process for identifying residents with the same or a similar name. The policy did not include the following requirements of the *Judgement Support Framework:*

- The roles and responsibilities in relation to the identification of residents.
- The required use of two appropriate resident identifiers prior to the administration of medications, the undertaking of medical investigations, or the provision of other services.
- The required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.

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

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

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

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

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

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

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

Evidence of Implementation: The approved centre's menus were approved by a staff dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. There was a choice of hot meals at both lunchtime and teatime. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly, and fresh drinking water was available at all times.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Their special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

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

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

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in the large open plan domestic kitchen. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

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

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

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy on residents' clothing. Relevant staff interviewed were not able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. No resident had been prescribed night clothing during the day since the last inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, religious, and cultural practices. Residents had an adequate supply of individualised clothing.

The 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 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 policy in relation to residents' personal property and possessions, which was last reviewed in October 2017. The policy included the requirements of the *Judgement Support Framework* with the exception of the communications with residents and their representatives regarding residents' entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant 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: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre's policy.

Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions where necessary, but residents usually kept their own possessions. Sharps objects were stored in the nurse's station. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in October 2016. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The process for risk-assessing residents for recreational activities, including outdoor activities.
- The methods of communicating recreational activities and individual activities programmes to the residents.

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 recreational activities, as set out in the policies.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a record of resident uptake and attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission.

Activities included TV, music, DVDs, books, and computer games. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre offered access to a large domestic garden and facilitated visits to the local community, based on risk assessment.

The large communal areas and sitting room available was suitable for recreational activities. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at activities were maintained in individual clinical files.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in October 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 had not been reviewed to ensure that it reflected the identified needs of residents since 2016.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre. Residents had access to multi-faith chaplains, if required. Residents had access to local religious services and were supported to attend following a risk assessment. The care and services provided within the approved centre were respectful of residents' religious beliefs and values. Residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

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 and procedures in relation to visits, which was last reviewed in October 2016. The policy included requirements of the *Judgement Support Framework* with the following exceptions:

- Details of the arrangements and appropriate facilities for children visiting a resident.
- The required visitor identification methods.

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: There were no restrictions on residents' rights to receive visitors at the time of the inspection. Analysis was completed to identify opportunities to improve visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The large group room was available for children visiting and it had art supplies.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to resident communication, which was last reviewed in October 2016. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities for resident communication processes.
- The assessment of resident communication needs.

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

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

Evidence of Implementation: Residents had access to mail, fax, email, internet, telephone, and their own mobile phone. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. The relevant senior staff member only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others. This was done in the presence of the resident and with the resident's consent.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches, which was last reviewed in March 2018. The policy addressed the requirements of the *Judgement Support Framework*, with the following exceptions:

- The considerations to be provided to residents in relation to their dignity, privacy, and gender during searches.
- The requirement to record searches, including the reason for the search.

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

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

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches.

A record of a search was inspected. Risk had been assessed prior to the search appropriate to the type of search being undertaken. The resident's consent was sought and documented, prior to the search taking place.

The resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being

conducted. The search was implemented with due regard to the resident's dignity, privacy and gender, at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

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

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policies and protocols in relation to care of the dying, which was last reviewed in October 2016. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The supports available to other residents and staff following a resident's death.
- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere (e.g. for general health care services).

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

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in March 2018. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The comprehensive assessment of residents at admission and on an ongoing basis.
- The required content in the set of documentation making up the ICP.
- The time frames for assessment planning, implementation and evaluation of the ICP.
- Residents' access to their ICPs.

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

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

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

Residents were initially assessed at admission and an initial ICP was completed by the admitting clinician to address the immediate needs of the resident. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission. The ICP was a documented set of appropriate goals for each resident, specified the treatment and care required, and identified the resources required to provide the care and treatment specified. ICPs were reviewed by the MDT weekly.

Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP. When a resident declined or refused a copy of their ICP, the reason for their refusal was not consistently 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 processes, training, 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 March 2018. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The resource requirements of the therapeutic services and programmes.
- The review and evaluation of therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.
- The provision of therapeutic services and programmes by external providers in external locations.

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

Monitoring: The range of services and programmes provided in the approved centre were 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: Therapeutic services and programmes provided by the approved centre were evidence-based, varied, and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents.

All therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Weekly therapies and services included individual psychotherapy, dietetics on a group basis and on a one to one basis, family therapy, art therapy, a self-esteem group, coping with emotions, assertiveness, and relapse prevention, body image, and a group using the principles of cognitive behavioural therapy, and yoga.

Therapeutic services and programmes were provided in separate dedicated rooms. Adequate resources and facilities were available. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents' clinical files.

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

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities for the resident transfer process, including the responsibility of the multi-disciplinary team and resident's key worker.
- The interagency involvement in the transfer process.
- The process for managing the transfer of involuntary patients.
- The processes for ensuring the safety of the resident and staff during the resident transfer process.

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

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

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

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

- The management of emergency response equipment, including resuscitation trolley and Automated External Defibrillator (AED).
- The protection of resident privacy and dignity during general health assessments.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre did not have an emergency resuscitation trolley but it did have basic emergency equipment. Staff had access at all times to an AED. Emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with their individual care plans.

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. When residents were assessed at admission, all residents received an assessment of their cardiac status through an electrocardiogram, a physical examination, a body mass index assessment, and their weight was measured. At the time of the inspection no resident was stayed in the approved centre for over six months.

Adequate arrangements were in place for residents to access general health services and to 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 were provided with information on and access to national screening programmes appropriate to age and gender.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

Training and Education: 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 the provision of information to residents, as set out in the policies.

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

Evidence of Implementation: Residents were provided with a handbook on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements. Details on relevant advocacy and voluntary agency details and residents' rights were not detailed in the information booklet, but were displayed in the main reception. Residents were provided with details of their multi-disciplinary team. The booklet was available in the required formats to support resident needs and the information was clearly and simply written.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition.

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

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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 policy in relation to resident privacy. The policy addressed the requirements of the *Judgement Support Framework* with the exception of the approved centres layout and furnishing requirements to support resident privacy and dignity.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were discreet when discussing residents' condition or treatment needs. Residents wore clothing that respected their privacy and dignity.

All bedrooms were locked from 8.30am to 7pm as part of the residents' care and treatment. If residents required access to their bedroom during the day this was facilitated under the supervision of staff. All bathrooms, showers, and toilets had locks on the inside of their doors which had an override facility. Rooms were not overlooked by public areas. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

Where residents shared a room, the bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make and take private phone calls and all residents had their own mobile phones.

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

Regulation 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 had a written policy in relation to its premises, which was last reviewed in October 2016. The policy addressed the requirements of the *Judgement Support Framework* with the following exceptions:

- The legislative requirements to which the approved centre premises must conform.
- The approve centre's cleaning programme.
- The approved centre's utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.

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

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

Evidence of Implementation: The approved centre environment and overall physical structure was conducive to the well-being of residents, staff and visitors. It was clean, hygienic and free from offensive odours. Lighting, heating and ventilation was adequate. The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, routine maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment in place. Records were maintained. Appropriate signage and sensory aids provided supported resident orientation needs.

Furnishings were adequate and suitable for the number and mix of residents. Accommodation for each resident in the approved centre assured their comfort and privacy and met their assessed needs.

Residents were accommodated in five single bedrooms and two residents shared a double bedroom with en suite facilities. The total bed capacity was seven.

All bedrooms and communal rooms were appropriately sized to meet residents' needs. There were two therapy rooms in the approved centre. There was a sufficient number of toilets and showers for residents. Hazards were minimised in the approved centre. Ligature points were reduced to the lowest practicable level. Back-up power was not available in the approved centre.

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, monitoring, and evidence of implementation 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, which was last reviewed in October 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policy and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and seven of these were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, and details of dosage, and frequency of medication. However, two MPARs inspected did not have micrograms written in full, instead the abbreviation ‘mcg’ was detailed. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR. A record was kept when medication was refused by or withheld from the resident.

While the administration route for the medication was written in all MPARs, one MPAR did not detail a record of all medications administered to the resident.

All entries in the MPAR were legible, and written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration; and expired medications were not administered. Medication was reviewed frequently and where there was a significant change in the resident’s care or condition. This was documented in the resident’s clinical file.

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

Medication was stored in the appropriate environment, as advised by the pharmacist. Refrigerators used for medication were used only for this purpose, and a daily log was completed of fridge temperatures.

Food and drink was not stored in areas used for the storage of medication. The medication press remained locked at all times and secured in a locked room.

An inventory of medications was conducted on an individual resident basis every month, checking the quantity, name, dose, and expiry date of medications. The supply of medication for each resident was stored on an individual basis.

The approved centre was non-compliant with section 1 of this regulation for the following reasons:

1. **One of MPARs did not detail a record of all medications administered to the resident, 23 (1).**
2. **Two MPARs inspected did not have micrograms written in full, instead the abbreviation mcg was detailed, 23(1).**

Regulation 24: Health and Safety

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors, which was last reviewed in March 2018. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- Specific roles are allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- Availability of staff vaccinations and immunisations.
- Management and reporting of an infection outbreak.
- Support provided to staff following exposure to infectious diseases.
- Specific infection control measures in relation to infection types, e.g. C.difficile, MRSA, Norovirus.

Training and Education: 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 policy.

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

Quality Rating **Satisfactory**

(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 the recruitment, selection, and vetting of staff. All policies were in-date. The policies combined included the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.

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

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

Evidence of Implementation: There was an organisational chart 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 policies and procedures for recruitment, selection, and appointment. Staff had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

Opportunities were made available to staff by the approved centre for further education. The number and skill mix of staffing were sufficient to meet residents' needs. A written staffing plan was available within the approved centre. 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.

Staff were trained in manual handling, infection control and prevention, resident rights, and risk management and treatment, incident reporting, recovery-centred approaches to mental health care and treatment, and the protection of children and vulnerable adults. All health care staff were trained in the following:

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

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM	0-1	0-1
	RPN	1	1
	HCA	1	1
	Therapists including dietician	sessional	

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

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 monitoring pillars.

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in the residents' records.
- Privacy and confidentiality of resident record and content.
- The process for making a retrospective entry in residents' records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Not all resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Records had no loose pages. Resident records were physically stored together. Records were developed and maintained in a logical sequence. Resident records were maintained using two identifiers which were unique to the resident. Not all residents' records were maintained and used in accordance with national guidelines and legislative requirements. The clinical file of one discharged resident contained clinical documentation pertaining to another resident.

Not all resident records were reflective of the residents' current status and the care and treatment being provided. A nursing entry which reflected the resident's current status and the care and treatment provided was recorded in the incorrect section of the clinical file in error and then crossed out.

Only authorised staff made entries in residents' records, or specific sections therein. Hand-written records were legible, written in black indelible ink, and were readable when photocopied. Entries were factual, consistent, accurate, and did not contain jargon, unapproved abbreviations, or meaningless phrases.
Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre. Residents' access to their records was managed in accordance to the Data Protection Acts.

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

a) **The registered proprietor did not ensure that records and reports were maintained in a manner to ensure accuracy. The clinical file of one discharged resident contained clinical documentation pertaining to another resident.**
b) **The registered proprietor did not ensure that the approved centre had written policies and procedures, specifically in relation to the creation of records, 26(2).**

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in March 2018. It included a the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities in relation to the development, management, and review of operating policies and procedures.
- The process for the development of the operating policies and procedures required by the regulations, incorporating relevant legislation, evidence-based best practice, and clinical guidelines.
- The process for approving operating policies and procedures.
- The process for disseminating operating policies and procedures, either in electronic or hard copy.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The process for making obsolete and retaining previous versions of operating policies and procedures.
- The standardised operating policy and procedure layout used by the approved centre.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review timeframes. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

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

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

The format of the operating policies and procedures was standardised, but there was no policy reference number and revision of the policy and procedure detailed on the policy. 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 rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, monitoring, and evidence of implementation pillars.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints, which was last reviewed in March 2018. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, 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: No formal complaints were raised by a resident since the last inspection. Minor complaints were not monitored.

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

Minor complaints were documented in the minor incident log book. There was also a process for dealing with issues raised at the weekly resident meetings.

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 monitoring and evidence of implementation pillars.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

Training and Education: While it was reported that staff had been trained in risk management processes this was not documented. Clinical staff were trained in individual risk management processes. Management staff were trained in organisational risk management. All staff had received training in incident reporting and documentation and part of the induction 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 risk management processes, as set out in the policy.

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 timeframes 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 director of services, 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 practicable level of risk. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at resident admission and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained but were effectively mitigated.

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. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The risk manager reviewed incidents for any trends or patterns occurring in the service.

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

The approved centre was compliant with this regulation. The quality assessment was 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 pillar.

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 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 and attached conditions relating to it were displayed prominently in 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)

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre at the time of the inspection. Please refer to section 5.3 of this report for areas that were not applicable on this inspection.

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of Mental Health Act 2001 was not applicable to this approved centre at the time of the inspection. Please refer to section 5.3 of this report for areas that were not applicable on this inspection.

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.

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 a series of separate written policies in relation to admission, transfer, and discharge:

- The admission policy was last reviewed in March 2018, and it covered the requirements of the code of practice with the exception of the following: it did not detail the procedure for involuntary admission, or referral letters protocols in relation to planned admissions.
- The transfer policy was last reviewed in March 2018, and it did not detail the procedure for involuntary transfers.
- The discharge policy was last reviewed in March 2018 and it did not detail the procedure for involuntary patients, or the protocol for discharging homeless people.

Training and Education: 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 discharge policy but not the admission and transfer policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. 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 multi-disciplinary team 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. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A comprehensive discharge summary was issued within two 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.

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

a) **The discharge policy did not detail the protocol for discharging homeless people, 4.12.**
b) **Audits had not been completed on the implementation of and adherence to the admission and transfer policies, 4.19.**

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

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

Report reference: Pages 39 & 40

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. One of MPARs did not detail a record of all medications administered to the resident, 23(1).	*Reoccurring*	Corrective Action(s): New drug Kardex to be introduced. Post-Holder(s) responsible: Clinical Director	Weekly audits of drug Kardex x 12 weeks and then to be reviewed by team re audit effectiveness and frequency required.	Achievable	8th April 2019
		Preventative Action(s): All clinical staff to have completed Medication Management Training. Post-Holder(s) responsible: Clinical Nurse Manager		Achievable	31st January 2019
2. Two MPARs inspected did not have micrograms written in full, instead the abbreviation mcg was detailed, 23(1).	*New*	Corrective Action(s): New drug Kardex to be introduced with clear instructions that abbreviations are not permitted Post-Holder(s) responsible: Clinical Director	.	Achievable	31st January 2019
		Preventative Action(s): All clinical staff to have completed Medication Management Training. Post-Holder(s) responsible: Clinical Nurse Manager	Weekly audits of drug Kardex x 12 weeks and then to be reviewed by team re audit effectiveness and frequency required.	Achievable	8th April 2019

Regulation 27: Maintenance of Records

Report reference: Pages 44 & 45

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. The registered proprietor did not ensure that records and reports were maintained in a manner to ensure accuracy. The clinical file of one discharged resident contained clinical documentation pertaining to another resident.	*New*	Corrective Action(s):): Maintenance of Records Policy to be reviewed and updated Post-Holder(s) responsible: Registered Proprietor	All clinical files of discharged patients each month will be audited to ensure accuracy.	Achievable	Immediate
		Preventative Action(s): All staff made aware of the Maintenance of Records Policy Post-Holder(s) responsible: Clinical Nurse Manager	Learnings to be shared at weekly team meetings.	Achievable	Immediate
4. The registered proprietor did not ensure that the approved centre had written policies and procedures, specifically in relation to the creation of records, 26(2).	*Reoccurring*	Corrective Action(s): Maintenance of Records Policy to be reviewed and updated to include the creation of records. Post-Holder(s) responsible: Registered Proprietor	Policy to be audited to ensure compliance	Achievable	31st January 2019
		Preventative Action(s):): All staff made aware of the Maintenance of Records Policy specifically in relation to the creation of records Post-Holder(s) responsible: Director of Services		Achievable	31st January 2019

Code of Practice: Admission, Transfer and Discharge

Report reference: Pages 58 & 59

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
5. Audits had not been completed on the implementation of and adherence to the admission and transfer policies, 4.19.	*New*	Corrective Action(s): Audit questionnaire to be revised to include implementation of and adherence to the admission and transfer policy. Post-Holder(s) responsible: Registered Proprietor	Audit to be conducted on the implementation and adherence to the admission and transfer policy.	Achievable	31st January 2019
		Preventative Action(s): All staff to receive training on Code of Practice: Admission, Transfer and Discharge to include audits on the implementation of and adherence to the admission and transfer policies. Post-Holder(s) responsible: Director of Services	Learnings to be shared at weekly MDT	Achievable	31st January 2019